MURRAY WOMAN'S CLINIC

305 S 8th St • Murray, KY 42071
270-753-9300 • 270-753-3549 (fax)

**** MINORS ****
Complete and attach the Minor Information form

Patient Information

Date of Birth _____ Race _____

Name _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____

Place of Employment _____

Spouse or Parent's Name _____ Phone Number _____

Spouse or Parent's Address _____

In case of an emergency who should be notified? _____ Phone Number _____

Relationship to emergency contact? _____

Pharmacy Name and Phone Number _____ Which City? _____

Do you have a signed Power of Attorney or Medical Directive? ☐ Yes ☐ No (If yes, please provide copy for your records).

Who referred you to our office?

☐ Referred by another physician (If so, by whom?) _____

☐ Another Patient ☐ Convenience of Location ☐ Radio ☐ Newspaper

☐ Doctor Finder ☐ BellSouth Yellow Pages ☐ West KY Lake Directory

☐ Other Phone Book (Please List) _____

☐ Other Referrals (Please List) _____

Insurance Information

Primary Insurance Company _____ Phone Number

Address of Insurance Company _____

ID # / Policy # _____ Group Number _____ Group Name (Employer) _____

Subscriber Name _____ Date of Birth _____ Relationship _____

Secondary Insurance Company _____ Phone Number

Address of Insurance Company _____

ID # / Policy # _____ Group Number _____ Group Name (Employer) _____

Subscriber Name _____ Date of Birth _____ Relationship _____

Financial Responsibility, Authorization and Consent

I authorize the assignment of insurance benefits to Murray Woman's Clinic, PLLC and understand and acknowledge that I am responsible for payment of all items and services, regardless of insurance benefits, provided to me by Murray Woman's Clinic. I authorize Murray Woman's Clinic to furnish information to insurance carriers concerning my illness and treatments. I acknowledge that my account must be kept current and any past due balances are due prior to my next visit. Failure to pay outstanding balances may result in the rescheduling of an appointment. Co-pays, deductibles and non-covered services will be collected at the time services are rendered. I have been given Murray Woman's Clinic's financial policy and agree to its terms. I consent to the use and disclosure of my confidential health information for the purposes of treatment, payment and/or practice operations. **Murray Woman's Clinic's policy is to call and remind patients of upcoming appointments and a message may be left on an answering machine, voice mail or given to a family member. It is your responsibility to advise your doctor or nurse of any special request for confidentiality now or in the future.** A photocopy of this assignment is considered to be the same as the original.

If I am pregnant or become pregnant, I agree to pay all deductibles / co-pays prior to delivery.

**This authorization/consent will remain in effect until revoked in writing.

_____ _____ _____ _____

Signature of Patient Date Signature of Responsible Party Date