

**Patient Information**

First Name (Legal Name) Last Name Middle Initial Preferred Name
Home Address City State Zip Code

Date of Birth Primary Number Home Cell Secondary Number Home Cell

Social Security Number Relationship Status: S M W D Sep Email Address (used for appointment reminders)

Insurance Policy Holder's Name, if not patient:

Patient Employer Employment Status FT PT Self Retired
Patient Work Phone Student Other

Emergency Contact Name: Number Relationship

**Minnesota State/Federal Government REQUIRES we ask the following questions**

Primary Language (circle one) Race (circle one) Ethnicity (circle one)
English Spanish Somali Other Caucasian Hispanic Asian Hispanic or Latino Not Hispanic or Latino
Chinese Other African American Other Religion

**Primary Care Doctor**

Primary Care Doctor/Clinic? Phone: Address/Location:

**Referral Information**

Who can we thank for referring you to us? Dr. Friend/Family Website
(First and Last Name)

Are you a previous patient of Dr. Kristen Nelson? YES NO
Did you transfer to CHCW because of our Pampered Pregnancy Program? Yes or No

**Discloser of Information Permission Form**

I hereby grant permission for the Comprehensive Healthcare for Women, P.A. doctors, staff or designees to discuss my care or any information in medical chart including billing statements with the following person(s). I understand that this written notification is effective immediately and indefinitely and can only be revoked or changed by myself in writing. This is in accordance with HIPPA regulations.

Name of Person: Relationship

**Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Compliancy**

I hereby authorize Comprehensive Healthcare for Women, P.A., or its designees, permission of treatment. I further authorize release of information necessary to file and adjudicate claims with my insurance company and assign benefits, otherwise payable, to Comprehensive Healthcare for Women, P.A. I agree that I am responsible for paying Comprehensive Healthcare for Women, P.A. and any balances due including co-pays, deductibles and non-covered services, which remain after insurance payments have been made. If full payment cannot be made, I agree to make payment arrangements with Comprehensive Healthcare for Women, P.A representative. By signing this form, I am acknowledging that I have received and/or have access to the Notice of Privacy Policy Practices from/of Comprehensive Healthcare for Women, P.A. I'm also aware I will be charged the following Fees:

- \$35 fee if I no-show for any of my appointments
• \$25 fee for not paying my co-pay at time of service, if one is required
• \$25 fee for all checks returned unpaid by bank
• \$35 late fee if no payment is made on my account within 60 days of receiving my first statement
• \$100 fee if my account is forward on to an outside collection agency.

Patient Signature Date