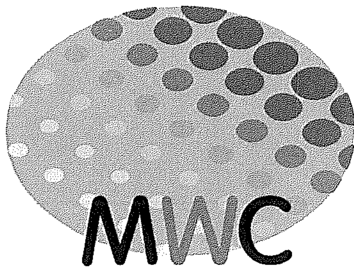


Mesquite Womens Clinic

1301 Bertha Howe Ave
Suite # 2
Mesquite, Nevada 89027
Telephone 702-345-.2122 fax 702-345-3063
www.mesquitewomensclinic.com

In an effort to provide timely service and accessibility to all our patients, effective February 1, 2007 Mesquite Women's Clinic will assess a $25 charge for no-show appointments and those canceled within 24 hours. (This will not be billed to the insurance company. It is the patient/family responsibility.) Additionally, a fee of $25 will be charged for patients who cancel and reschedule their appointments three (3) times or more.

The above fee will be due and payable prior to the next appointment. Should payment not be remitted prior to your next scheduled appointment, it will be due in addition to your co-pay.

We appreciate your understanding and anticipated cooperation in this matter.

Sincerely,

Mesquite Women's Clinic Staff

Mesquite Womens Clinic

1301 Bertha Howe Ave Suite 2 Mesquite NV 89027

Patient Information:

Last Name____________________________ First Name_________________________________

Date of Birth___________________ Social Security Number___________________________

Mailing Address____

City________________________ State__________________ Zip____________________________

Home Phone__________________ Cell/Text___________________ Work ___________________

Employer____

E-Mail Address____

Sex Female/Male **Marital Status** M/ S/ D/ W **Race** Asian/ Caucasian/ Hispanic/ African American/ Other

Responsible Party Information (If patient is under 18):

Last Name______________________________ First Name_________________________________

Mailing Address____

City____________________________ State_______________________ Zip__________________

Home Phone_______________________________ Cell_______________________________

Subscriber Information For The Insurance:

Last Name____________________________ First Name_______________________________

Date of Birth______________________ Social Security Number_______________________

Mailing Address____

City_____________________________ State_______________________ Zip__________________

Home Phone_______________________________ Cell___________________________________

Employer____

PLEASE ENSURE THE OFFICE A COPY OF YOUR CURRENT DRIVERS LICENCE

INSURANCE COVERAGE INFORMATION

Primary Insurance

Insured (Name on Card)________________________ Insured Id Number_________________

Insurance Company Name______________________ Group Number____________________

Address________________________________ Effective Date_______________

Secondary Insurance

Insured (Name on Card)________________________ Insured Id Number_________________

Insurance company Name______________________ Group Number____________________

Address________________________________ Effective Date_______________

Third Insurance

Insured (Name on Card)________________________ Insured Id number_________________

Insurance Company Name______________________ Group Number____________________

Address________________________________ Effective Date_______________

IN CASE OF AN EMERGENCY…

Name and Phone Number Of Someone Not Living With You

________________________________ ________________________

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN

I hereby authorize the office of Mesquite Womens Clinic, to release any medical information required during the course of examination and treatment and permit payment directly to them any benefits due for to their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible, and non-covered services.

Date_______________ Signature of Patient/Guardian________________________________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Mesquite Womens Clinic, for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

Date____________________ Signature of Patient/Guardian________________________________

HOW WERE YOU REFERRED TO THE PRACTICE……

Dr.____________________ Friend/Relative Newspaper/Radio

Address__________________________ Phone Number( )________________________

Mesquite Womens Clinic

CONSENT TO TREATMENT:
I voluntarily consent to receive medical and health care services provided by Mesquite Womens Clinic (MWC)/Dr. Edward Ofori/June Franzen, Nurse Practitioner. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand this consent will be valid and remain in effect as long as I remain a patient at MWC.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION:
A copy of ***'Confidentiality and Release of Medical Records'*** is available for you to read at the front desk. A copy for your records will be made available to you by request. By signing this form, you consent to MWC use and/or disclose protected health information as stated in the ***'Confidentiality and Release of Medical Records'*** for treatment, payment, healthcare operations and as otherwise allowed by law.

RELEASE FROM LIABILITY:
I release and agree to hold harmless MWC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand MWC cannot be responsible for use of redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:
In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services otherwise payable to me to MWC. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer, up to the total amount of my medical and health care charges to MWC. I certify that the information I have provided in connection with my application for payment by third party payers, including Medicare/Medicaid is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payer and agree to make payment as requested by MWC.

I certify that this form has been fully explained to me, that I have read it or had it read to me and I understand its contents.

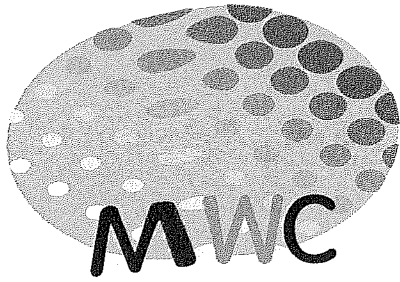
Print Patient Name:______________________________ Date:______________

Patient/Guardian Signature:____

Relationship to patient:____

MWC OFFICE STAFF:

Witness____



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We ask that you are aware of your health insurance benefits with your insurance company; what services are covered, to what lab a specimen (such as blood test or pap test) should be sent, and that you have reviewed the amount of your deductible. If you have any questions about your insurance coverage please call your insurance company directly.

Below, please circle the lab which you desire your tests to be sent to. The lab will be sending you a separate lab bill. If the lab is not covered by your insurance, you will be responsible for the balance. If you have a question about your lab bill, please contact the lab.

Please circle and initial the lab of your choice:

QUEST **LABCORP** **LMC**

Please note that if you have a specimen sent to pathology for the **HALO Breast Test**, that specimen will automatically be sent to LMC.

Patient signature and date:____