

# SUSAN B. WINCHESTER, M.D., F.A.C.S.

Today's Date	Chart Number	New	Return	Change	Delete
<b>PATIENT INFORMATION</b>					
Patient's Last Name		First	Middle		
Mailing Address			Marital Status	Date of Birth	Age
City		State	Zip Code	Social Security No.	
Home Phone No.		Work Phone No.	Cell No.	Driver's License No./State	
Patient's E-mail		Employer's Name			
Occupation		Employer's Address			
Name of Spouse		Spouse's Social Security No.		Spouse's Date of Birth	
Spouse's Employer's Name		Spouse's Work Phone No.		Spouse's E-mail	
Occupation		Spouse's Work Address			
Referred by			Phone No.		
<b>IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)</b>					
Name		Home Phone No.	Work Phone No.	Relationship to Patient	
<b>AUTHORIZATIONS AND ACKNOWLEDGEMENTS</b>					

I hereby authorize Susan B. Winchester, MD, PC to discuss my medical and payment information with:

Name (1)	Relationship	Phone Number	Name (2)	Relationship	Phone Number
Name (3)	Relationship	Phone Number	Name (4)	Relationship	Phone Number

I acknowledge that I have received a copy of Susan B. Winchester, MD's Notice of Privacy Practices which explains how my protected health information may be used and disclosed, certain restrictions on the use and disclosure, and rights I may have regarding my protected health information.

I authorize the staff of Susan B. Winchester, MD to call my home or work phone number and leave a message on my voice mail or recorder regarding office appointments and/or surgery information.

I authorize the release of any medical information necessary to process a claim on my insurance policy(ies). I hereby assign and authorize payment directly to the office of Susan B. Winchester, MD all benefits payable under such insurance policy. I agree to pay the remaining balance including amounts not covered by insurance. I understand that no oral or written contract exists which designates by name or description the individual who will treat the patient.

In the event of default in the payment of my charges, I agree to pay 33% of the principle balance for collection costs should the account be referred to a collection agency or an attorney for collection plus court costs expended. I further agree to waive my rights of exemption as to personal property. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

I understand that it is my responsibility to ensure a medical referral is obtained if required by my insurance company. In the event no referral is obtained, I agree to pay all charges.

The authorizations and acknowledgements will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

\_\_\_\_\_  
Patient's or Responsible Party's Signature

\_\_\_\_\_  
Date