URGENT

WOMEN'S HEALTH BOUTIQUE®
DALLAS ~ LONGVIEW ~ OAK CLIFF ~ PLANO ~ TYLER

Customer Information/Release Form

Date: _____

☐ Return Customer ☐ New Customer

Reason for Visit: ☐ Mastectomy: (Surgery date):_____ ☐ Compression
☐ Maternity (due Date:_____) ☐ Other: _____

Are you Currently in a ☐ **Nursing Home** ☐ **Skilled Nursing Facility** ☐ **Hospice Care: Y N if Yes what for: _____**

Primary Dr, PA, or NP you currently see:. _____

Name: _____ Last 4 of SSN# _____

Address: _____

City, State and Zip Code: _____

DOB: _____ Phone #: _____Cell/Home (circle one) Phone#: _____ Cell/Home/Other

Email: _____

***Please have your driver's license and insurance card(s) available for us to make a current copy.**

Do you still work or your spouse if over 65? _____

Insurance Billing Release and Patient Responsibility of Charges PLEASE INITIAL

1. ___ I hereby authorize the Women's Health Boutique to furnish my health insurance company, other third-party payers, or their designated agents with all the information which the above-named entity may request concerning treatment of the patient named above.
2. ___ I understand that regardless of verified insurance coverage, in the event my premiums are not paid, my deductible is not met, my insurance company denies charges, or my insurance company determines charges are patient liability, I am responsible for all fees for services rendered to above patient and it is my financial responsibility to make payment to Women's Health Boutique.

HIPAA Release

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).
Please print the name and relationship for each person to whom you are authorizing to release your private health care information, account balances or pick up your products.

Name: _____ Relationship:_____ Phone#: _____
Name: _____ Relationship:_____ Phone#: _____
Name: _____ Relationship:_____ Phone#: _____

Release of Medical Records

To: All my Healthcare Providers of Treatment
I_____ request that any medical records needed pertaining to claims at Women's Health Boutique be faxed to 214/948/3993 or be mailed to appropriate location on cover page. I, the customer, understand that my healthcare information is to be used for treatment, payment or for healthcare operations only. I (the customer) also understand that my healthcare information may also be disclosed to other healthcare providers for the purposes of treatment, payment or for healthcare operations pertaining specifically to me.
This form expires 7 years from signature date unless patient revokes in writing this authorization.

_____ _____
Customer Signature **Date**

PLEASE NOTE IF YOU DON'T LIST ANYONE ON HIPAA RELEASE WE CAN'T SPEAK TO ANYONE BUT YOU ABOUT YOUR ACCOUNT.