



ARBOR HEALTHCARE FOR WOMEN

PO Box 925 - 780 Swift Boulevard, Suite 310
Richland, Washington 99352
(509) 946-7900
Fax (509) 946-7944

Account Information

Account #:

Patient Name: _____

Date of Birth: _____

Address: _____

SS Number: _____

Marital Status: _____

Home Phone: _____

Work Phone: _____

Emergency Contact: _____

Emergency Phone: _____

Employer: _____

E-Mail Address: _____

Insurance Information (Primary)

Ins Company: _____

Effective Date: _____

Address: _____

Phone: _____

Policy #: _____

Group #: _____

Copay Amount: _____

Deductible: _____

Insurance Information (Secondary)

Ins Company: _____

Effective Date: _____

Address: _____

Phone: _____

Policy #: _____

Group #: _____

Copay Amount: _____

Deductible: _____

I certify that the above information is true, to the best of my knowledge. I authorize Arbor Healthcare for Women to submit my medical claims directly to my insurance company and to release any information acquired in the course of the examination in order to receive payment for such examination or treatment. I also authorize Arbor Healthcare for Women to initiate a complaint to the insurance commissioner on my behalf. I understand that regardless of insurance status, I am ultimately responsible for the balance of my account for all services rendered.

Signature

Date