Women's Integrative Health

Angelica M. Zaid, M.D.
Sieu Truong, M.D.
Samina Makani, M.D.
Obstetrics, Gynecology, & Fertility

Patient Information

Last Name | Maiden Name | First Name | Middle Name

"Nickname" | Drivers Lic # | State Issued

Home Address | City | State | Zip Code

Home Phone | Mobile Phone

Work Phone | Other Phone

Circle Contact Phone # Preference: Home Phone | Mobile Phone | Work Phone | Other Phone

Social Security # | Birth Date | Age | Sex | Marital Status | Email Address

Patient's Employer | Work Address

Emergency Contact Name | Address | Phone

Responsible Party for Medical Charges (If Different From Above Information)

Last Name | Maiden Name | First Name | Middle Name

Home Address | City | State | Zip Code | Home Phone

Occupation | Work Address | Work Phone

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay full allowances for certain procedures, and others only pay a percentage of the charge.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical/surgical benefits to Women's Integrative Health /Angelica Zaid, M.D. / Sieu Truong, M.D./ Samina Makani, M.D., and I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy / scan of this agreement shall be as valid as the original. Additionally,

- I understand that not all services are a covered benefit in all insurance contracts and some insurance companies arbitrarily select certain services that they will not cover.
- I acknowledge my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company.
- I understand that deductibles are subject to collection prior to services being rendered.
- I understand that cash discounts will only be available at the time of office visit or, in the case of emergency procedures up until thirty days after the emergency procedure – after this time, the discount will be removed and I will be responsible to pay the full price charged.
- I understand that returned checks and balances older than 30 days will be subject to additional collection fees and interest charges.
- I understand that I will be a billed service charge for passing bad checks – service charges will be twenty-five dollars ($25) for the first bad check and thirty-five dollars ($35) for each subsequent check. I understand that if I pass a check on insufficient funds I will be liable for the amount of the check plus damages (Civil Code 1719). The law sets damages at three times the amount owed, but not less than one hundred dollars ($100) or more than one thousand five hundred dollars ($1500).
- I understand that a Well-Woman Exam / Annual Exam / Exam with Pap Smear may not be covered by my insurance company (including Medicare) and, if not covered, I will be responsible for paying the full charge.
- I understand that any discounts previously offered will be removed if my account is sent to collections and I will then be responsible for all charges on my account.
- I will notify Women's Integrative Health of changes to my billing address and/or health insurance.

Signature: _____ Date: _____

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