Centre For Women, Family & Child Health

878 West Bay Rd, Caribbean Plaza, Unit 15 C,
P. O. Box 10708, Grand Cayman KY1-1006.
Email: hdeosaran@forhealth.ky
Phone: (345) 943 4666

PATIENT INFORMATION

PATIENT NAME:

First Name: _____ Middle: _____ Last Name: _____

Date of Birth: Month: _____ Day: _____ Year: _____

Sex: □ Male □ Female

Employer: _____

Address: P.O. Box: _____ Postal Code: _____

House/Apt #: _____ Street: _____

State/District: □ WB □GT □ BT □ EE □ NS Other: _____

Cell Phone: ( ) _____ Work/Direct: ( ) _____

E-mail Address: _____

INSURANCE INFORMATION

PRIMARY INSURANCE – Effective:
Insurance Name: _____
Group/Plan #: _____ Policy/Member #: _____
Subscriber Name: _____ Relationship to patient: _____
Copay amount: _____
Are you covered by a second insurance company? □Yes □No
If yes, Second Insurance Company: _____
Group #: _____ Policy/Member #: _____
Subscriber Name: _____
Date of Birth: _____

PRIMARY CARE PROVIDER

Primary Care Physician: _____ Phone: _____

EMERGENCY CONTACT

Name: _____ Phone: ( ) _____

Relationship: _____

The above information is true to the best of my knowledge. I authorize treatment for myself or the above individual and I understand that I am ultimately responsible for the charges associated with the medical services and agree to pay all bills within 30 days from the receipt of a statement, unless other arrangements are made. I authorize the physician and the Centre For Women, Family & Child Health to release any information required to process my insurance claims. I understand that my medical record may contain information regarding HIV/AIDS, substance abuse, mental health, sexually transmitted diseases, sickle cell anemia, and other sensitive information. I also authorize my insurance to directly pay Centre for Women, Family and Child Health.

Patient signature _____ Date _____

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The Centre for Women, Family and Child Health is committed to providing you with the best possible care. If you have medical insurance we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

1. **INSURANCE:** All insurance companies are billed directly as a courtesy. Any remaining balance for non-covered benefits and deductibles are your responsibility. Payment for this is expected within 30 days from receipt of your statement.

2. **CO-PAYS:** All co-pays are expected at the time the service is rendered.

3. **NON-CONTRACTED INSURANCE:** If your insurance company is not contracted with the CWFCH all charges are considered patient responsibility at the time of service. As a courtesy, the CWFCH will provide you with a claim to send to your insurance for reimbursement.

4. **METHOD OF PAYMENT:** We accept cash, checks, Discover, VISA or MasterCard.

5. **RETURNED CHECKS:** There will be a $25.00 charge for all returned checks.

6. **SERVICE FEE:** There is an interest fee accrued on ALL accounts with balances 30 days and over, regardless of payment arrangements or secondary insurance status.

7. **DIVORCED, SEPARATED, OR BLENDED FAMILIES:** In order to keep our accounts clean and eliminate any embarrassing or uncomfortable situations for you, we have chosen NOT to become involved in any agreement, understanding, and/or court order regarding reimbursement from the absent parent. Payment is required at the time of service. Reimbursement from the absent parent is your responsibility.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

GUARDIAN INFORATION (Complete if patient is under age 18 or a Disabled Adult)

Name: _____ Relationship: _____

Date of birth: Month: _____ Day: _____ Year: _____

Cell Phone: ( ) _____ Work/Direct: ( ) _____