

ASSOCIATES FOR WOMEN'S HEALTH

NAME _____ AGE _____ DOB _____
LAST FIRST MI
MAILING ADDRESS _____ APT# _____
CITY _____ STATE _____ ZIP CODE _____
EMAIL ADDRESS _____
SSN _____ HOME# () CELL# ()

MARITAL STATUS? Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐

STUDENT STATUS? Full-time ☐ Part-time ☐ Not a student ☐

EMPLOYMENT STATUS? Full-time ☐ Part-time ☐ Not employed ☐ Self-Employed ☐ Retired ☐

ETHNICITY? Caucasian ☐ Hispanic ☐ African American ☐ Other ☐

PREFERRED LANGUAGE ? English ☐ Spanish ☐

APPOINTMENT REMINDER CALL? Home ☐ Cell ☐ Text Message ☐ Work ☐

WOULD YOU LIKE TO ACCESS YOUR RECORDS ONLINE THROUGH OUR PATIENT PORTAL? YES ☐ NO ☐

HOW DID YOU HEAR ABOUT US? YELLOW PAGES ☐ ONLINE ☐ OTHER ☐

EMPLOYER _____ WORK# () EXT _____

1. EMERGENCY CONTACT _____ PHONE# () (RELATION) _____

2. EMERGENCY CONTACT _____ PHONE# () (RELATION) _____

POLICY HOLDER INFO _____ RELATION _____ DOB _____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE) _____

SSN _____ HOME# () CELL# ()

EMPLOYER _____ WORK# () EXT _____

PRIMARY INSURANCE _____ EMPLOYER PLAN? YES ☐ NO ☐

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

GROUP# _____ ID# _____ INSURANCE PHONE # ()

POLICY HOLDER _____ RELATION _____ DOB _____

SECONDARY INSURANCE _____ EMPLOYER PLAN? YES ☐ NO ☐

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

GROUP# _____ ID# _____ INSURANCE PHONE # ()

POLICY HOLDER _____ RELATION _____ DOB _____

THIRD INSURANCE _____ EMPLOYER PLAN? YES ☐ NO ☐

INSURANCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

GROUP# _____ ID# _____ INSURANCE PHONE # ()

POLICY HOLDER _____ RELATION _____ DOB _____

PRIMARY CARE PHYSICIAN? _____ REFERRED BY _____

PHARMACY NAME _____ LOCATION _____

I HEREBY AUTHORIZE payment directly to Surendher Lokareddy MD PC of the group benefits otherwise payable to me (The benefits from Health/Medical Insurance.) I understand that I am financially responsible for charges not covered by this authorization. I also understand that if I do not give a 24 hour notice to cancel an appointment, I am financially responsible for the applicable fees. I authorize Surendher Lokareddy MD, PC and his staff to receive medical records from other facilities for my medical treatment. I authorize the release of my medical information necessary to process the insurance claim. I also authorize any physician to use any information, which is necessary for the processing of my insurance. I agree to pay any reasonable attorney fees, court costs, collection costs and interest incurred, if I default in payment of any charges incurred by me with the above named physician.

SIGNATURE _____ DATE _____

**ASSOCIATES FOR WOMEN'S HEALTH
1945 W. 24TH STREET
YUMA, AZ 85364
(928) 341-4650**

THIS LETTER IS DESIGNED TO GIVE YOU SOME INFORMATION REGARDING OUR PRACTICE AND THE OPTIONS YOU HAVE.

- **WE HAVE ONE DOCTOR (DR. LOKAREDDY) AND THREE CERTIFIED NURSE-MIDWIVES (KATHLEEN EMBREE, LETICIA FERNANDEZ, ELIZABETH MARTINEZ) IN THIS PRACTICE. YOU HAVE THE OPTION OF CHOOSING YOUR PROVIDER.**
- **ANY LABS DONE IN THIS OFFICE WILL BE SENT OUT TO THE RESPECTIVE LABORATORIES. YOU ARE REQUIRED TO KNOW WHICH LAB YOUR INSURANCE IS CONTRACTED WITH SO WE CAN SEND ANY SPECIMENS TO THAT RESPECTIVE LABORATORY. THIS OFFICE IS NOT RESPONSIBLE FOR ANY LAB BILLS.**
- **THIS PRACTICE IS NOT RESPONSIBLE FOR ANY BILLS FROM ANY OUTSIDE FACILITY.**
- **THIS OFFICE IS OPEN FROM MONDAY TO FRIDAY 9-5 PM. IF YOU NEED TO REACH ANY PROVIDERS AFTER OFFICE HOURS, PLEASE CALL THE OFFICE NUMBER AND AN ANSWERING SERVICE WILL FORWARD YOUR MESSAGE TO THE PROVIDER ON-CALL.**
- **THIS PRACTICE SHARES CALL WITH ANOTHER PRACTICE (SAN LUIS WALK IN CLINIC). ONE OF THESE DOCTORS WILL ALWAYS BE ON CALL FOR THIS PRACTICE.**
- **AS A COURTESY THIS PRACTICE WILL BILL YOUR INSURANCE. YOU ARE REQUIRED TO PAY ANY AMOUNT THAT YOUR INSURANCE APPLIES TO YOU WITHIN 60 DAYS. YOU WILL ALSO BE RESPONSIBLE FOR ANY SERVICES NOT COVERED UNDER YOUR INSURANCE.**
- **PREGNANT PATIENTS WHO DO NOT HAVE INSURANCE ARE REQUIRED TO BRING \$130.00 FOR THEIR FIRST OFFICE VISIT. THIS WILL BE REFUNDED TO YOU AFTER YOUR INS PAYS US FOR THE SERVICES RENDERED. IF YOU DO NOT HAVE INSURANCE BY YOUR SECOND OFFICE VISIT YOU WILL BE REQUIRED TO BRING A PAYMENT ACCORDING TO YOUR CONTRACT. ANY ULTRASOUNDS DONE DURING YOUR REGULAR OFFICE VISIT ARE NOT MEDICALLY COMPREHENSIVE. A COMPLETE ULTRASOUND WILL BE SCHEDULED FOR YOU AT THE APPROPRIATE TIME.**
- **GYN PATIENTS WHO DO NOT HAVE INSURANCE ARE REQUIRED TO PAY THE COMPLETE AMOUNT CHARGE ON THE DATE OF SERVICE.**

I HAVE READ THE ABOVE NOTICE AND I UNDERSTAND ITS CONTENTS. I AGREE WITH THE ABOVE TERMS.

PATIENT SIGNATURE _____ DATE _____

WITNESS _____ DATE _____