Preferred Women's Care
Geoff Zimmerman, M.D.
2222 Greenhouse Road #300
Houston Texas 77084
281-398-8484

Patient Name:_____
Last First Middle Int
Address:_____ APT _____

City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ext._____

Cell Phone: ( )_____ E-Mail Address:_____

Social Security #:_____-_____-_____ Driver's License #:_____ State:_____

Date of Birth:_____/ _____/ _____ Martial Status: (circle one) S M D W

Primary Care Physician:_____ Referred By:_____

Patient's Employer:_____ Occupation:_____

Emergency Contact:_____ Phone#: ( )_____

Responsible Party (if patient is a minor)

Name:_____ Date of Birth:_____

Address:_____ Phone: ( )_____

Relationship to patient:_____

Insurance Information

Policy Holder:_____ Policy Holder DOB:_____

Policy Holder's SSN #:____-_____-_____

Insurance Company:_____ Member #:_____

Group #:_____ Relationship: (circle one) Self Spouse Child

Secondary Insurance Company:_____Policy Holder DOB:_____

Policy Holder's SSN#: ____-_____-_____

Member #:_____ Group#:_____

Preferred Women's Care

General Consent for Treatment

I, knowing that I have a medical condition or physical check-up requiring diagnostic, medical or surgical treatment; do hereby voluntarily consent to such procedures, care, medical, surgical, and other services under the general and specify instruction of Dr. Zimmerman, his assistant or his designee as is necessary in his judgment.

I also acknowledge that the practice of medicine is not exact science and that no guarantees have been made to me as to the result of treatment or examination by Dr. Zimmerman.

_____ _____

Patient's Signature Date

Preferred Women's Care

We Appreciate the Opportunity of Serving You.
We Pledge To Give You Our Very Best Medical Care.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time services are given, unless prior arrangements have been made. All accounts over 60 days will be charged an interest of 1½ percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all costs charged by the collection company, which costs will not exceed 20% of said unpaid balance, including any reasonable attorney fees.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment as needed.

I authorized the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

Signed:_____ Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Preferred Women's Care and Dr. Zimmerman's Notice of Privacy Practices. I have reviewed the Policy which explains how my health information will bye used and disclosed, and I understand that I am entitled to a copy of this document.

Signature of patient or personal representative Date

Printed name of patient or personal representative Relationship