STEPHANIE TAYLOR, M.D., Ph.D
PATIENT INFORMATION SHEET

Patient Name:____ Date:____________
First M.I. Last

Mailing Address:____________________City:________ State:____Zip Code:________

Street Address (if different from mailing):____

Home Phone:______________Cell Phone:______________Work Phone:____________

Date of Birth:___________________________________Marital Status:____________

Email Address:____

Employer:____
Name Address City, State, Zip Code

Primary Care
Physician:____
Name Address City, State, Zip Code

Emergency
Contact:____
Name Home Phone Cell Phone

What Pharmacy do you use?:____
Name Address City

HOW DID YOU HEAR ABOUT US?_____________________________________

INSURANCE INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION BELOW AND PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST (TO BE ATTACHED TO YOUR LAB ORDER)

SELF-PAY: (circle one) *Non Provider* *No Insurance*

Primary Insurance:________________Insured's Name:________________DOB:________

Insured's address (if different from above):____________________________________

Relationship to Insured (please circle one): *Self* *Spouse* *Child* *Other* Insured's SSN#:__________

Insured's
Employer:____
Name Address City, State, Zip Code

Physician charges will be due at time of service. We will courtesy bill your insurance company. You are responsible to contact your insurance prior to services to determine if services provided are covered.

I consent to treatment for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to insurance carriers as needed to process a claim. I allow fax transmittal of medical records if necessary. I understand that I am financially responsible for all charges.

Patients Signature:________________________ Print Name:______________________

Stephanie Taylor, M.D. Ph.D.
26365 Carmel Rancho Blvd., Ste. F
Carmel, CA 93923

Office Hours:
Monday - Thursday 8:00 am - 4:30 pm
Closed for lunch 12:30 pm - 1:30 pm

Financial Policy

PLEASE READ, COMPLETE AND SIGN IN THE AREA BELOW.

As of January 1, 2010, Dr. Taylor will no longer be a provider of your insurance. We **will** courtesy bill your insurance company. **This does not apply to Medicare and Tricare patients.**

Medicare and Tricare patients: Dr. Taylor does not have a UPIN number, therefore, you **cannot** submit for reimbursement. **Medicare recommends patients who send bills to Medicare after signing the Private Contract, be discharged from care.** ____
initial here

Payment is due at the time of service. We accept cash, check, Visa, MasterCard or Discover as means of payment. There is a **$25.00** charge for any returned checks.

There is a **$75.00** fee for cancellation of appointments with less than 24 hour notice and **$75.00** for any missed appointments.____
initial here

Current insurance cards must be presented at each visit to be attached to your lab order.

I have elected to see Dr Taylor and have been informed that she is not a provider with my insurance plan. I will pay for services at the time they are rendered.

I have read, understood, and agreed to the above financial policy for payment of professional fees. I am ultimately responsible for all professional fees, as well as knowing my insurance policy coverage and limitations.

____

Patient Signature Print Name Date

Acknowledgement of Receipt of Notice

Stephanie Taylor, M.D., Ph.D.
26365 Carmel Rancho Blvd., Ste F
Carmel, CA 93923
Tel: (831) 622-1995
FAX: (831) 622-1999
www.womanswellspring.com

Karla-Privacy officer

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________.

Signed: ______________________ Date: ______________________

Print Name: ______________________ Telephone: ______________________

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: ______________________

***For Office Use Only*:**

❑ Signed form received by: ______________________

❑ Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

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