EVE'S BREAST CENTER
PATIENT DEMOGRAHIC FORM

Last Name:	First Name:
Address:	DOB: Gender:
City,State, zip	Cell #:
Email:	

INSURANCE INFORMATION

Relationship To Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child**	
Policy Holder Name:	
Insurance Name:	Primary Policy :
Secondary Insurance:	Secondary Policy:

☐ **Yes - Authorization to Release Pateint Information:** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is composed of two main rules. The HIPAA privacy rule provides privacy of an individual's personally identifiable health information. The HIPAA SecurityRule establishes standards for the privacy of electronic health information HIPAA protects consumers from having their health information unnecessarily disclosed. The Department of Health & Human Services' Office for Civil Rights enforces HIPAA rules.

☐ **Yes - Acknowledgement of Privacy Practices, and HIPPA disclosure agreement:** I understand that in an attempt to protect the privacy of my identifiable health information, Eve's Breast Center has established guidelines for privacy within our offices.This information details the use and/or disclosure of information contained in my personal medical records kept for the purpose of diagnosis, treatment, payment and healthcare options in accordance to HIPPA Regulations. By my signature below, I acknowledge I have read and understand the Privacy Practices and HIPAA regulations disclosure

☐ **Yes - Financial Responsibility:** I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by the representative of Eve's Breast Center. I assign and authorize payments to Eve's Breast Center.
I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates,benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for any non-covered services, provided for pre-existing conditions, and not paid in full,copayments ,payment plan and policy deductibles and coinsurance except where my liability is limited by contract or state or federal law**.**

Any patient turned over to collections can and will lose any and all discounts given, be responsible for any collection fees, attorney's feesand any fee acquired will be reported to the appropriate credit agencies. Please be aware that any returned check will be charged $35.00 and subject to any collection fees as well.

By my signature below, I swear and affirm all information I have entered is true and correct to the best of my knowledge. I also agreethat intentionally misrepresenting information can be construed as fraud and can and will be punished to the fullest extent of the law.

Patient/GuardianSignature: Date: