Menopause Center of Minnesota

Patient Information

First Name (Legal Name) | **Last Name** | **Middle Initial** | **Primary Name**

Home Address | **City** | **State** | **Zip Code**

Date of Birth | **Primary Number** Home Cell | **Secondary Number** Home Cell

Email (used for appt reminders) | **Patient Employer** | **Work Phone**

Emergency Contact | **Emergency Contact Phone** | **Relation to Patient**

Insurance Policy Holder's Name, if not patient | **Policy Holder's Date of Birth**

Primary Care Doctor

Doctor/Clinic | **Phone** | **Location**

Referral Information

How did you hear about us? Doctor/Friend/Family or Online Search/Advertisement

Disclosure of Information Permission Form

I hereby grant permission for Menopause Center of MN providers, staff or designees to discuss my care or any information in my medical chart including billing statements with the following person(s). I understand that this written notification is effective immediately and indefinitely and can only be revoked or changed by myself in writing. This is in accordance with HIPPA regulations:

Name of Person: **Relationship:**

Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Compliancy

I hereby authorize Menopause Center of MN , LLC providers permission of treatment. I further authorize release of information necessary to file and adjudicate claims with my insurance company and assign benefits, otherwise payable to Menopause Center of MN. I agree that I am responsible for paying Menopause Center of MN any balance due including co-pays, deductibles and non-covered services, which remain after insurance payments have been made. Payment for out of network insurance services are due at time of service. By signing this form, I am acknowledging that I have received and/or have access to the Notice of Privacy Policy Practices from/of Menopause Center of MN. I am also aware I will be charged the following fees:

~ $35 fee if I no-show or give less than a 24 hour notice for any of my appointments

~ $35 late fee if no payment is made on my account within 60 days of receiving my first statement

I have read and fully understand and agree to the terms of the financial policy set forth by the Menopause Center of MN

Patient Signature **Date**