The Center for Women

Obstetrics & Gynecology

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J. Harley Barrow, Jr., M.D. – Erik P. Shultz, M.D. – Amanda Thornton, A.N.P. – Ste 2A
628 Hospital Drive – Mountain Home AR 72653
(870) 425-7300 / (870) 424-4164 fax

Patient Name: _____ Initial Appointment Date: _____
Last First Middle Initial

PERSONAL:
Maiden Name: _____ DOB: _____ Sex: _____ Race: _____

Address: _____

City: _____ State: _____ Zip: _____

TELEPHONES:
Home: _____ Work: _____ Cell: _____ Primary # to call 1st: _____

Pager: _____ Fax: _____ Email: _____

SSN: _____ Religion: _____ Marital Status: _____

Driver's License #: _____ Primary Language: _____

Employer Name: _____ Working: Full Time or Part Time

Telephone & Extension: _____ Hire Date: _____ Occupation: _____

Spouse Information:

Spouse Name: _____ Date of Birth: _____ SS#: _____

PRIMARY INSURANCE:
Insurance: _____ Effective Date: _____ Policy Holder: _____

Policy #: _____ Group #: _____

SECONDARY INSURANCE:
Insurance: _____ Effective Date: _____ Policy Holder: _____

Policy #: _____ Group #: _____

PATIENT AGREEMENT:

I, the undersigned, authorize Dr. Mary Wren, Dr. Harley Barrow Jr., Dr. Erik Shultz or Amanda Thornton, ANP to release to my insurance company any medical records or information required by them to process any claims submitted for my care. I understand my medical insurance may not cover the fee(s) for professional and/or technical services rendered to me and that I am responsible for these fees. I authorize payment of medical benefits due me to be paid directly to any provider with The Center for Women listed above. A photocopy of this agreement shall be valid as the original. I understand FULL PAYMENT IS DUE AT THE TIME OF SERVICE for:

- any co-pays, co-insurances, or deductibles for insurances The Center for Women is participating with
- payment in full for any insurances The Center for Women IS NOT participating with OR
- payment of patients without insurance.

I may ask for an estimate of fees prior to services being rendered and further understand they may not include any additional or future services ordered for my medical care. Financial arrangements may be made with a counselor for surgical and obstetrical services. Accounts not paid or maintained as in any payment agreements set, are eligible for collection measures. The cost for any collection measures taken will be the responsibility of the patient.

Patient/Legal Guardian Signature: _____ Date signed: _____