CORNERSTONE
WOMEN'S CARE

Annual Wellness Exam – New Patient

Patient Name

_____ _____
First Name *Last Name*

_____ _____
Date Doctor

_____ _____
Pharmacy Phone

_____
Address/City/State/Zip

Insurance issues, requirements and coverage are ever changing. We are making every effort to be in compliance and to eliminate payment denials before they occur. Your insurance plan may or may not cover routine preventative services *(Well Woman Exam/Wellness Exam)*.

We are legally obligated to assign procedure codes based on the services provided to you, whether it is a *Well Woman Exam* or a visit to take care of problems or both. We cannot change the coding later to cause the insurance company to pay for a non-covered service.

Based on the kind of coverage you have, some or all of the cost may have to be billed to you.

Please keep in mind that while the appointment may be just for a *Well Woman Exam* or just for problems, if both kinds of services are provided during a visit, then both services may be billed. If both services are billed, you may be responsible for paying a co-payment for each service, depending on your insurance coverage.

We thank you for taking time to complete this form. We are making every effort to comply with governmental rules and the rules of all insurance plans for claim submission. We appreciate the help of our patients in this endeavor.

Please Indicate the Purpose of Your Visit As You Understand It—

❍ Well Woman Exam ❍ Additional Blood/Lab Work ❍ STD Testing* ❍ Problem(s) – *list below*

_____

_____

**** It is your responsibility to check with your insurance to see if these services are covered***

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