PATIENT INFORMATION SHEET

NOTE: YOU WILL BE REQUIRED TO FILL OUT THIS FORM EVERY 6 MONTHS

Please Complete All Information On This Form

Mr. Mrs. (Please Print)

Ms. Dr. **Patient Name:** ______________________________

Address: ______________________________

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E-mail: ______________________________

Single Married Widowed Partnered Student Male Female

SSN: ______________ Home Phone ______________

Birth Date: ____/____/____ Cell Phone: ______________

Employer: ______________ Work Phone: ______________

Spouse/Parent: ______________ Work Phone: ______________

Employer: ______________ Occupation: ______________

PERSON RESPONSIBLE FOR BILL (if other than patient, i.e. parent/spouse/guardian):

Name: ______________ Phone: ______________

Birth Date: ______________ Employer ______________

Occupation: ______________

EMERGENCY CONTACT OUTSIDE OF HOME: Relationship: ______________

Name: ______________ Phone: ______________

Referred by (How did you hear about us?): ______________________________

Primary Physician: ______________________________

Clinic Address: ______________ Send Report: Yes No

City: ______________ Zip: __________ Phone: __________ Fax: __________

Are you being seen as the result of an auto accident? No Yes – please provide the following information:

Date of Accident: __/__/____ Time: _______ State in Which Accident Occurred: ______________

INSURANCE INFORMATION: Please fill in completely using your insurance card

PRIMARY: ______________ Group#: ______________

ID #: ______________ Phone#: ______________

Subscriber: ______________ Claims Address: ______________

Relationship: ______________ **DOB:** __/__/__ ______________

SECONDARY: ______________ Group#: ______________

ID #: ______________ Phone#: ______________

Subscriber: ______________ Claims Address: ______________

Relationship: ______________ **DOB:** __/__/__ ______________

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I understand that I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment of any of my charges. I am financially responsible for a billing fee and understand that balances over 60 days may incur a billing fee of 1% per month (12% APR), (RCW19.52), with a minimum charge of $1.00 monthly. I have also been informed of the $25.00 fee (per RCW 62A.2-515&520) on checks returned for NSF. In the event it should become necessary to place any unpaid balance due for services rendered to me or my family for collection, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing fees and other costs the court determines proper.

Medicare Authorization: I authorize the doctor to release to the Federal Government or its designated agent information on this or related medical claims. I permit a copy of this authorization to be used in place of the original and request payment of my insurance benefits be made to myself or to the doctor if assignment is accepted. o Lifetime o Ending ____/____/____

Phone Messages/e-mail/Mail: I authorize **NWFACE** to leave messages at my home or alternate number or be contacted via the e-mail address I have provided for all administrative issues. I also authorize **NWFACE** to send me information regarding special officers, promotions, new products or services, and reminders to the address that I have provided.

Privacy: We are required by law to maintain the privacy of, and provide individuals with, a notice of our legal duties and privacy practices with respect to protected health information. A signature below only acknowledges that you have received the **NOTICE OF HEALTH INFORMATION PRATICES OF NORTHWEST FACE** handout.

Patient or Guardian Signature: ______________________ **Today's Date**: ______________

INTERNET REGISTRATION USERS PLEASE SIGN AT THE OFFICE IN FRONT OF A WITNESS