*3610 ENSIGN RD NE*
*OLYMPIA, WA 98506-5025*

## PATIENT REGISTRATION

**PATIENT'S NAME** ______________________________________________
Last First Middle Initial

**Age** _____ **Date of Birth** ______________ **Marital Status:** S D M W **Sex:** M F **Social Security #** __________________

HOME PHONE ( )________________ CELL PHONE ( )________________ WORK PHONE ( ) ___________________

Street Address________________________________________________ City ____________________ State ______ Zip _________

Mailing Address_______________________________________________ City ____________________ State______ Zip ________

Patient's Employer____________________________ Phone ( ) ______________ Is primary insurance through employer? Y N

Emergency Contact__________________________________ Relationship _________________ Phone ( )_________________

Please initial and date every 6 months if information is still current ___________ ___________ ___________ ____________

## REFERRING PHYSICIAN

Referring Physician _______________________________________________ Phone ( ) __________________________________

Primary Care Physician ___________________________________________ Phone ( ) __________________________________

Please initial and date every 6 months if information is still current __________ __________ __________ ________________

### PLEASE PRESENT TO THE RECEPTIONIST:

- **Current insurance card(s)**
- **Photo identification with current address information**
- **Applicable co-payment**

## INSURANCE INFORMATION

**If patient is 18 and under, or someone other than patient is responsible for payment, please complete this section.**

Name of responsible party ________________________________________ DOB _________________ SS# ___________________

Relationship to patient ___________________________________

| PRIMARY INSURANCE | SECONDARY INSURANCE |
|---|---|
| Ins. Company Name _________________________________ | Ins. Company Name _________________________________ |
| Effective Date _____________________________________ | Effective Date _____________________________________ |
| Subscriber's Name __________________________________ | Subscriber's Name __________________________________ |
| Relationship to patient ______________ Gender: M F | Relationship to patient ______________ Gender: M F |
| Subscriber's DOB ________________ | Subscriber's DOB ________________ |
| Subscriber's SS# _____________________ | Subscriber's SS# _____________________ |
| Subscriber's ID# ___________________________________ | Subscriber's ID# ___________________________________ |
| Group # ___________________________________________ | Group # ___________________________________________ |
| Subscriber's Employer ______________________________ | Subscriber's Employer ______________________________ |
| Employer's Phone ( ) ________________________ | Employer's Phone ( ) ________________________ |

**ADDITIONAL INSURANCE** ___________________________________________________________________________________

**DSHS**: Please present coupon. **HEALTHY OPTIONS**: Present coupon and card. **SELF-PAY?** ❑ Y ❑ N

**WORK RELATED INJURY: L&I CLAIM #** _________________________ **Date of Injury** __________________________

Employer _____________________________________________ Employer Phone _________________

Claims Manager Name and Phone # ________________________________________________________________________________

State of WA _____ Self-Insured _____ Address ___________________________________________________________

Please initial and date every 6 months if insurance information is still current__________ __________ __________ _________

## MEDICARE PATIENTS ONLY

This is to advise you that our annual status changed with Medicare in 2003; as of March 1, 2003, we are contracted with Medicare as NON-ASSIGNED MEDICARE PROVIDERS. What this means to you as a patient is:

- We will bill the Medicare limiting charge established by Medicare.
- Medicare will send the Summary Notice with the payment to the patient.
- You may return your payment with the Summary Notice to Surgical Associates for secondary billing unless your Summary Notice indicates that your private health insurance has been billed.

The above does not apply if your insurance is Medicare/Medicaid or Medicare/Group Health.

We understand patients frequently have questions regarding their insurance coverage. We encourage you to call our Business Office to answer any questions that you may have regarding your specific insurance.

Please sign below to acknowledge understanding of the above information.

**SIGNATURE:** ________________________________________ **Date:** ______________________

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## ALL PATIENTS

**Financial Agreement and Authorization for Treatment**

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be Thurston County.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) I understand that if I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, or if my exam has not been properly authorized by my PCP and/or insurance company prior to my appointment date, I am liable for all services rendered.

I authorize Surgical Associates, PLLC to bill my insurance carrier and that the payment will be sent directly to the provider. I authorize Surgical Associates, PLLC to release necessary medical information to process insurance claims, complete insurance forms or disability statements.

THIRD PARTY AUTO INSURANCE CASES ARE THE PATIENT'S RESPONSIBILITY. WE DO NOT WAIT FOR SETTLEMENT.

**SIGNATURE:** ________________________________________ **Date:** ______________________

**AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION**

Protecting your privacy is very important to us at Surgical Associates. For us to remain compliant with the Federal Health Insurance Portability and Accountability Act (HIPAA), we ask that you check all contact information which applies.

Patient name_______________________________________ Date of Birth ______________________

☐ May leave message on voicemail at home number. ( )_________________________________

☐ May leave message on voicemail at work number. ( ) _________________________________

☐ May leave message on cell phone number. ( ) _________________________________

☐ May leave message with spouse or significant other: Name _________________________________

☐ May leave message with other family member: Name _________________________________

I understand the staff and physicians of Surgical Associates have my permission to provide health care information via the above checked boxes. I can amend this at any time and it is my responsibility to keep the list current.

____________________________________________________ Date ___________________________

Please initial and date every 6 months if information is still current _______ ________ ________ ________