Overlake Obstetricians and Gynecologists, PC

PATIENT REGISTRATION FORM

Account Number_____ Physician Name _____ No._____ Date _____ Employee Initials _____

NAME _____
LAST FIRST M.I.

NAME _____
FORMER NAMES (MAIDEN, ETC.) PREFERRED NAME (NICKNAME, ETC.)

BIRTHDATE _____ AGE _____ SSN _____
MM / DD / YY

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIV ☐ SEP ☐ WID DRIVERS LICENSE# _____ PRIMARY LANGUAGE _____

RACE: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Caucasian ☐ Other ☐ Declined
ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined

ADDRESS _____
APT# CITY STATE ZIP

HOME ( ) _____ WORK ( ) _____ CELL ( ) _____ PRIMARY NUMBER ☐ HOME ☐ WORK ☐ CELL

EMAIL _____ ☐ PERSONAL ☐ WORK

HOW DID YOU HEAR ABOUT US ? ☐ WEBSITE ☐ REFERRAL ☐ AD

EMPLOYED BY _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE ( ) _____

PRIMARY CARE PHYSICIAN _____ REFERRED BY _____ PREFERRED PHARMACY _____

SPOUSE'S NAME _____ BIRTHDATE _____
LAST FIRST M.I. MM / DD / YY

EMPLOYED BY _____ OCCUPATION _____

INSURANCE INFORMATION

PRIMARY _____ ID# _____ GROUP# _____

SECONDARY _____ ID# _____ GROUP# _____

IS ANYONE OTHER THAN PATIENT THE MAIN POLICY HOLDER ON INSURANCE? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE POLICY HOLDER'S INSURANCE INFORMATION

POLICY HOLDER'S INSURANCE INFORMATION

NAME OF INSURED _____
LAST FIRST M.I.

RELATIONSHIP TO INSURED _____ ID# _____

BIRTHDATE _____ EMPLOYED BY _____
MM / DD / YY

LOCAL EMERGENCY CONTACT NAME OF PERSON *NOT* LIVING WITH YOU:

NAME _____ RELATIONSHIP _____ PHONE _____

(PLEASE GIVE ALL INSURANCE CARDS TO RECEPTIONIST)

04/14

(over)

INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release any information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account.

X SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Medical Records Department or Privacy Officer.

X SIGNATURE: _____ DATE: _____

FINANCIAL POLICY

It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our specialty. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. You will be responsible for all co-pays, deductibles, and co-insurance amounts not covered by a secondary insurance policy along with the entire amount of any non-covered service. For your convenience, we accept cash, personal checks, Visa and MasterCard. In order to best meet your needs, please call our business office at 425-454-6674 or refer to our website if you have questions regarding our financial policy. Patients who do not have insurance coverage (or proof of coverage) or who choose to pay for non-covered services are expected to pay in full at the time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our business office prior to receiving services.

X SIGNATURE: _____ DATE: _____

PREVENTATIVE CARE

Your health insurance plan may not provide coverage for preventive services. It is important that you contact your insurance provider to determine if your plan offers benefits for this service and what their scheduling guidelines are for it. We use industry standard codes and guidelines to submit claims to the insurance companies based on the scheduled encounter and documentation in the patient's medical record. Current laws regarding fraud and abuse with billing procedures prohibit us from changing the procedure codes and/or diagnosis codes in order to get the claim paid by the insurance company. DSHS does not pay for annual exams, payment is your responsibility.

X SIGNATURE: _____ DATE: _____

NOTICE TO ER PATIENTS

The purpose of this notice is to inform you that your visit in our clinic today is a referral for follow-up to your visit in the Emergency Room. Today's appointment is independent of your visit to the hospital and you will be billed for the services rendered. This visit does not establish you as a patient of Overlake Obstetricians and Gynecologists, PC.

X SIGNATURE: _____ DATE: _____

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

You may share the following health care information with:

Name: _____ Relationship: _____

Please check all that apply:

☐ All health care information in my medical record ☐ Insurance and billing information

☐ Health care information in my medical record relating to the following treatment: _____

☐ Other (appointments, test results, etc.)

This authorization ends:

☐ In 90 days from the date signed ☐ On (date): _____

- May leave detailed message on voicemail at: Home # _____ Work # _____ Cell # _____
- May leave information with: ☐ Spouse/Partner or ☐ Family Member Name: _____
- May send text to remind you of upcoming appointments ☐ Yes ☐ No to # _____

X SIGNATURE: _____ DATE: _____