



PATIENT INFORMATION (please print)

Patient's Name: _____ Birthdate: _____
Last First MI

Male Female Child Single Married Separated Other _____

Address _____
Street City State Zip

Mailing Address _____
City State Zip

Telephone _____ Social Security # _____ - _____ - _____
Home Work

Patient's Employer _____ Occupation: _____

Spouse's Name _____ Social Security # _____ - _____ - _____

Spouse's Employer _____ Telephone _____

IF PATIENT IS A MINOR (Under 18 Years)

Responsible Party _____ Relationship _____

Social Security # _____ - _____ - _____ Date of Birth _____

Address _____
Street City State Zip

Employer's Name & Address _____

Telephone _____
Home Work

REFERENCE:

Name of a relative or friend living at another address:

Name: _____ Relationship: _____

Address: _____ Telephone _____
Home Work

Whom may we thank for referring you? _____

INSURANCE INFORMATION

DSHS: Please present coupon

Primary Insurance: _____ Group# _____

Subscriber Name _____ Subscriber ID # or SS # _____ - _____ - _____

Effective Date: _____ Date of Birth _____ Relationship: _____

Secondary Insurance: _____ Group# _____

Subscriber Name _____ Subscriber ID # or SS # _____ - _____ - _____

Effective Date: _____ Date of Birth _____ Relationship: _____

FINANCIAL AGREEMENT, EXTENSION OF CREDIT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above. I understand that services provided may not be covered by my insurance carrier. I agree to be personally and financially responsible for payment in full of all fees and charges for such treatment, regardless of my insurance coverage and referral procedures. I agree to pay all charges for myself and members of my family shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing.

In accordance with the Federal Truth-in-Lending Act which requires us to give our patients information in connection with extension of credit, please be advised of the following policies which apply in this clinic. The responsible party agrees:

1. To pay the doctor at the time treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 60 days from the date of patient responsibility to pay 1% per month on the unpaid balance (annual rate of 12%) with a minimum charge of \$1 per month.
3. To pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.
4. To a \$50.00 charge for missed or cancelled appointments within 24 hours of the scheduled appointment time.
5. To a \$100.00 charge for missed or cancelled procedures within 72 hours of the scheduled appointment time.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the 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.

Signature of Responsible Person: _____ Date: _____

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (OBRA '90') ADVANCE DIRECTIVES

Do you have a living will? yes no

Do you have a durable power of attorney for health care? yes no

If not, do you wish additional information? yes no

The existence or execution of a living will, durable power of attorney for health care, or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate an individual.

Signature: _____ Date: _____

PAYMENTS OF BENEFITS - AUTHORIZATION

I authorize payment of medical benefits to the Olympia Multi-specialty Clinic for any services furnished me. I also authorize the release medical or other information necessary to process claims for these services provided.

Signature: _____ Date: _____

AUTOMATED TELEPHONE SYSTEM - AUTHORIZATION

I authorize Olympia Multi-specialty Clinic to use an automated telephone system and/or E-mail and to use my name, address, and phone number; the name of the treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other health care related communications. I also authorize Olympia Multi-specialty Clinic to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail or answering machine.

Signature: _____ Date: _____

CONFIDENTIAL MESSAGES ON ANSWERING MACHINE OR VOICE MAIL - AUTHORIZATION

I authorize Olympia Multi-specialty Clinic to disclose protected health information on my answering machine or my voice mail.

Signature: _____ Date: _____