

INSURANCE INFORMATION

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 to use my first name, the name of the treating physician, and the time and place of my scheduled appointment(s), for the limited purpose of notifying me of a pending appointment(s). I also authorize Olympia Multi-specialty Clinic to disclose to third parties who may answer my phone, limited protected health information regarding my pending appointment(s).

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: _____