

Valley Women's Clinic – Patient Registration Form

CIRCLE YOUR DOCTOR'S NAME: SLEETER RICE KIPA-JOSEPH TAGAVILLA

2009

PATIENT INFORMATION			
Your name:		Patient's SSN:	Patient's Date of Birth:
Maiden name:			
Your primary language:	How did you hear about us?	Your E-mail address	
Home address:		Home phone #:	
City:	State:	Zip:	Cell phone #
Your Occupation:		Your Employers name:	
Employer's Address:		Work phone # including extension:	
City:	State:	Zip:	Best number to reach you during the day:
IS IT OK FOR OUR OFFICE TO LEAVE MESSAGES TO REMIND YOU OF YOUR APPOINTMENTS?			
With a family member? YES NO		On an answering machine or voice mail ? YES NO	
IS IT OK FOR OUR OFFICE TO LEAVE MESSAGES REGARDING YOUR LAB & TEST RESULTS ?			
With a family member? YES NO		On an answering machine or voice mail? YES NO	
EMERGENCY CONTACT INFORMATION			
Name of person who you do not live with?		What is your relationship to this person?	
DAY phone number for emergency contact:		Evening emergency phone number:	
Marital Status:	Your marital status is: (please circle one) M S D W other		
PRIMARY INSURANCE INFORMATION			
Name of Insured (subscriber)		Name of Insurance company:	
Name and address of Employer:		Work phone # including area code & extension:	
Social Security or I.D. number:		Group or Claim number:	
Date of Birth:	Sex: Male Female		
Relationship to Patient:		Name of Primary Care Provider:	
SECONDARY INSURANCE INFORMATION			
Name of Insured (subscriber)		Name of Insurance company	
Name and address of Employer:		Work phone # including area code & extension:	
Social Security or I.D. number		Group or Claim number:	
Date of Birth:	Sex: Male Female		
Relationship to Patient:		Name of Primary Care Provider:	

PLEASE READ AND SIGN ALL **THREE** PLACES BELOW!

ASSIGNMENT OF BENEFITS – RELEASE OF INFORMATION FOR BILLING

I authorize treatment of the person named above and agree to pay all fees for such treatment. I also authorize the release of any medical information necessary to process these claims. I hereby authorize Valley Women’s Clinic to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance of 1% per month from the date of service, collection fees, reasonable attorney fees and court costs. I have also been informed of the \$50 fee (per RCW 62A.3-515 & 520) on checks returned NSF.

X SIGNATURE: _____ DATE: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 Coordinator or Privacy Officer. My signature acknowledges my receipt of the Notice of Privacy Practices for Valley Women’s Clinic.

X SIGNATURE: _____ DATE: _____

LAB WORK

We do not provide lab services. Your tests will be sent out of our office to **PACIFIC PHYSICIAN’S LABORATORY, INC**, our preferred lab. We will provide your insurance and billing information to the lab so they can bill your insurance directly. If your insurance company requires you to use a specific lab, please list the name of the lab on this line _____

It is your responsibility to advise our staff at the time of your visit. Payment for lab services is your responsibility and completely separate from services provided by our office.

CO-PAYMENTS

Co-payments are due on the date of service. We accept payment in cash, debit card, VISA and MASTERCARD. We will provide a receipt for all payments.

ANNUAL EXAMS

When you make an appointment for an annual exam, we will bill your insurance for an annual exam. Some insurance companies do not pay for annual exams – and it is your responsibility to check this out before your visit. We do not change procedure codes and appointment types after you have been seen.

Some insurance companies will only pay for an annual exam when it is done 366 days after your last annual exam. This means, if you have it before one year, your insurance may not pay for your visit or your lab work.

MEDICARE AND ANNUAL EXAMS

Medicare pays for an annual exam only once every TWO years. Because of this, you will be asked to sign a Medicare ADVANCED BENEFICIARY NOTICE form.

DSHS AND ANNUAL EXAMS

DSHS does not pay for annual exams. Payment for annual exams is your responsibility. You will be asked to sign a consent form advising you of this.

X SIGNATURE: _____ DATE: _____

MEDICARE PATIENTS ONLY: Please circle the correct answer	Have you purchased supplemental Insurance? (MG)		Do you currently have insurance Through an employer? (SP)	
	YES	NO	YES	NO