

**SEATTLE SPINE & SPORTS MEDICINE
PATIENT REGISTRATION**

Welcome to our office. We are committed to providing comprehensive care. Please assist us by providing the following information. **Please carefully and legibly fill in the appropriate sections below.**

Patient Full Name	Gender	SSN	Birthdate (MM/DD/YY)	
	<input type="checkbox"/> M <input type="checkbox"/> F			
Home Address		City	State	Zip
Mailing Address <input type="checkbox"/> SAME AS MY HOME ADDRESS		City	State	Zip
Home Telephone	Mobile Telephone	Work Telephone		
Please specify which physician or other health care provider has referred you:		Primary Care Provider: <input type="checkbox"/> SEND THEM REPORT		
EMERGENCY CONTACT				
Name	Relationship to patient			
Address <input type="checkbox"/> SAME AS MY HOME ADDRESS		City	State	Zip
Telephone: <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> WORK				
PERSON RESPONSIBLE FOR PAYMENT				
Name <input type="checkbox"/> SELF	Telephone			
Address <input type="checkbox"/> SAME AS MY HOME ADDRESS		City	State	Zip
PLEASE FILL OUT THIS SECTION IF THIS IS A CLAIM (e.g. MVA, L&I)				
Please specify claim type: <input type="checkbox"/> MOTOR VEHICLE – PIP <input type="checkbox"/> WORK-RELATED, Choose: <input type="checkbox"/> STATE L&I <input type="checkbox"/> Self-Insured L&I <input type="checkbox"/> OTHER:				
Date of Injury:	CLAIM NUMBER:			
Insurance Company Name	Telephone	Adjuster's Name		
Address	City	State	Zip	
Attorney Name, if applicable	Telephone			
Briefly describe how & where injury occurred: (e.g.: driving; on the job; at home, etc)				
HEALTH INSURANCE (i.e. NOT CLAIM-RELATED)				
Primary Insurance Company	Claim Address			
Subscriber's Name <input type="checkbox"/> SELF	Birthdate	Group No:	Primary Insurance ID No.:	
Secondary Insurance Company	Claim Address			
Subscriber's Name <input type="checkbox"/> SELF	Birthdate	Group No:	Secondary Insurance ID No.:	

**Thank you for taking the time to fill this out.
Please Review & Sign Our Financial Policy Agreement**

**SEATTLE SPINE & SPORTS MEDICINE
FINANCIAL POLICY AGREEMENT**

Patient Full Name: _____ **Birthdate (MM/DD/YY):** _____

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if **proper paperwork** is provided to us. We will also bill most secondary insurance companies for you. Your agreement with your insurance carrier is a private one, and we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. Interest will accrue monthly at 1% on all balances more than 30 days past due.

SECONDARY INSURANCE: Secondary insurance information should be provided to our office at your first visit. If this information is provided to our office after the first visit you will be charged a \$25 administrative fee. This fee will need to be paid prior to us submitting charges to your secondary insurance for you.

FEES: All co-pays, deductibles, and payments for non-covered services are due at the time of visit.

RETURNED CHECK FEES: Our office will charge \$25 for any checks returned as insufficient funds.

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office is willing to bill your motor vehicle PIP insurance, if available. You are responsible for payment at the time of service if you do not have this coverage.

WORKER'S COMPENSATION: If your injury is work-related, we will need the claim number and insurance carrier name prior to your visits in order to bill the worker's compensation insurance company.

MISSED APPOINTMENTS: In fairness to our other patients and our clinic, we require at least 24 hours' notice to cancel appointments. **Our clinic reserves the right to charge you a fee comparable to 50% of our expected usual and customary payment for: 1) missed appointments and 2) appointments with same-day cancellations. If you fail to pay this fee, you will be subject to dismissal from our clinic.**

If you miss 2 or more clinic visits with us, without giving at least 24-hour or any notice, we reserve the right to terminate your care with us.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all eligible medical benefits to which I am entitled, through private insurance and any other health plans, to **Seattle Spine and Sports Medicine**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

AUTHORIZATION TO RELEASE MOTOR VEHICLE PIP INSURANCE CLAIM BENEFIT INFORMATION:

I hereby authorize my motor vehicle PIP insurance company(ies) listed on my SEATTLE SPINE & SPORTS MEDICINE PATIENT REGISTRATION FORM to release claim information to this office and/or its medical billing service, including specifically the amount of remaining PIP coverage left on my policy.

I have been made aware that this office and/or its medical billing service may call the above-named motor vehicle PIP insurance company(ies) to obtain updated PIP coverage information at future times, depending on the extent of care required for my condition. **Therefore, please note that this agreement is valid until your account is settled or paid in full.**

I have read, understood, and agreed to the above financial policy for payment of professional fees.

Signature: _____ Date: _____