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FormLett

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:

Guarantor Information (to whom statements are sent)

Name:
Address:
Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone: ( ) _____ - _____

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _____ - _____

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): M or F
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

Signed _____ **Date:** _____

FINANCIAL ASSIGNMENT OF BENEFITS/PROMISE TO PAY:

Payment and Fees: Payment for your care is due at the time the services are provided; the only exception to this policy is if we are contracted with your insurance plan (See insurance below). If you have lab work or other services performed, there will be additional charges. Cash, check, debit cards, and credit cards are acceptable payment methods.

Insurance: You are required to present your insurance identification card at each and every visit. Insurance plans can change often, which requires us to review the information at each visit. We will submit a claim for your services to your insurance. It is your responsibility to verify in advance that the physician you have chosen to see is contracted with your plan. Any co-payments, co-insurance, and/or deductibles are due at the time of service. A co-payment is a fixed dollar amount that must be paid before the insurance will begin to pay. Again, if you do not have your current insurance identification card or an acceptable proof of insurance coverage, your visit will be considered self-pay, and you will be responsible for the full payment at the time of service. Insurance information must be updated during the timely filing period for the insurance. If updated information is not received during this time, the balance is considered your responsibility. At all times, it is your responsibility to follow up on all requests from your insurance company regarding claims and to question any unpaid insurance amounts. If you do not receive an explanation of benefits (EOB) from your insurance company within 60 days of your visit, please call your insurance for a status update on the EOB. Your insurance makes the final determination regarding payment at the time the claim is processed. If you feel this is incorrect, you must contact your insurance to appeal this. However, the balance will still remain your responsibility. In the event that your insurance does pay, a refund will be issued to you.

Wellness/Preventative Benefits: A wellness, annual or preventative exam is defined as a visit without complaints or illness. If you have insurance, our office will file your claim to reflect this. At the time your visit is scheduled, please specifically state that this is the reason you are seeing the doctor. Some insurance plans have benefits for wellness exams. If your visit includes a problem that is addressed or requires treatment, you may also be charged an additional office visit for the problem, along with the charge for the preventative visit. Please be familiar with your insurance benefits before seeing the doctor.

Referral/Primary Care Physician (PCP): If your insurance plan requires a referral from your PCP, it is your responsibility to request the referral from your primary care physician to be sent to our billing office. If your insurance plan requires a PCP to be assigned, it is your responsibility to contact your insurance and have PCP assigned for the day of service. Failure to obtain a referral or to have a PCP assigned when required may result in reduced benefits or non-payment by your insurance company, making you responsible for payment of your visit. I, the undersigned, have read and understand the financial policy as described above and agree to pay for any and all medical services including portions not covered or denied by my insurance. Failure to pay in a timely manner will result in my account being turned over to an outside collection agency.

OUR OFFICE WILL NOT CHANGE A DIAGNOSIS AFTER THE CLAIM HAS BEEN FILED. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO TALK WITH THE NORHTWEST HEALTH BILLING OFFICE.

NOTICE OF PRIVACY PRACTICES:

Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I have received a copy of the Physician Practice Group Clinics' Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Practice Group Clinics, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

_____ _____

Patient Signature/Legal Guardian, if a minor Date

PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):
I have been made aware and understand that the medical practices and offices may use an electronic prescriptions system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medication I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

I have been provided the Electronic Prescribing Notice included in the Notice of Privacy Practices.

SIGN HERE TO DECLINE E-PRESCRIBING: _____

GENERAL CONSENT FOR TESTS TREATMENT AND SERVICES:
In consideration of the care given and to be given to me, I hereby give consent to receive medical treatment, including medications and hospitalization. I hereby give consent to use necessary examinations, injections, tests, or immunizing treatments as in the opinion of the attending physician, physician assistant, or independent Advanced Practitioner. I hereby authorize the release of any requested medical information from private physicians and/or institutions.

RELEASE OF INFORMATION:
When calling my home or cell phone numbers, the following people may have access to the below healthcare information:

- O Appointments or scheduling information
- O Labs and/or outpatient test results
- O Lab/x-ray or outpatient test appointments information
- O Prescription refill information
- O Billing Information
- O Any other healthcare needs

List names of each individual: (WRITE N/A IF YOU DON'T AUTHORIZE ANYONE)

_____ Relationship to Patient _____
_____ Relationship to Patient _____
_____ Relationship to Patient _____

_____ _____
Emergency Contact Name Emergency Contact Phone Number

AUTHORIZATION TO LEAVE A MESSAGE: INITIAL ONE OF THE FOLLOWING

_____ I authorize my treating provider(s) and staff with Northwest Physicians, LLC to leave messages on my voicemail or answering machine regarding billing information, lab reports, other test results, prescription and medication information, appointment scheduling, and any other healthcare needs.
_____ I DO NOT authorize my treating provider(s) and staff with Northwest Physicians, LLC to leave detailed messages on my voicemail or answering machine.

_____ _____
Patient Signature/Legal Guardian, if a minor Date

VIDEO TAPING/RECORDING:

I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

PORTAL CONSENT AND AGREEMENT:

I consent to participation in the facility Patient Portal, and understand that my personal health and individually identifying information is made available to me in the Portal. I understand that the use of the Portal is for **NON-EMERGENCY** purposes. I understand that I have the ability to provide portal access to my Authorized Representatives and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading, and transmitting my health and individually identifying information. I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information. I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes. I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions. I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal. I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Sign Here to DECLINE the Portal: _____

AUTHORIZED USER ACCESS REQUEST:

Patient e-mail address: _____

Allow Portal access to my health information to the following individual:

Name: _____ DOB: _____ Relationship to Patient: _____

E-mail Address for authorized user: _____

Checkmark One Level of Access:

_____ **Guarantor Access** (allows users to access appointment scheduling and secure messaging with clinic staff ONLY)

_____ **Full Access** (allows users to access all sections of the patient portal)

_____ **Billing Access** (allows users to access billing information ONLY)

_____ _____

Patient Signature/Legal Guardian, if a minor Employee Signature

_____

Relationship to Patient

_____

Date

ADM

Notice of Communication Accessibility Services

Our staff wants to communicate effectively with you and your family members. Please fill out this paper and return it to Registration Clerk or your Nurse.
All of the communication accessibility aids and/or services that you need are **free of charge to you.**

Do you think you need any of the following aids and/or services?*	**YES**	**NO**
American Sign Language interpreter		
Oral interpreter		
TTY/TDD		
Hearing-aid compatible telephone receiver with volume control		
Television closed captioning		
Written/printed materials in other formats (i.e. large print, audio, accessible electronic or other formats as available)		
Written/printed materials in Braille (if available). Other alternatives will be made available to accommodate individuals who are blind or have limited vision.		

Additional aids and/or services may be available. Please list any other ways we may better communicate with you:

*Please note that some aids or services will only be necessary in certain situations.

I understand that this healthcare facility will not pay for any aids and/or services that I choose to provide *on my own.* I also understand that I can change my mind at any time and request that this healthcare facility provide aids and/or services at no charge to me.

Primary Spoken Language: _____
Patient's preferred language for discussing healthcare: _____
Interpreter services are available 24 hours per day.
Some Limited English Proficiency (LEP) persons may prefer or request to use a family member or friend as an interpreter. However, family members of friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of an interpreter at no charge to the person has been made. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services using the applicable CyraCom services will be provided to the LEP person.
Children and other clients/patients will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

This provider complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.
Call 1-479-751-5711 (TTY: 1-800-285-1131).

Este proveedor cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-479-751-5711 (TTY: 1-800-285-1131).

Nhà cung cấp này tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-479-751-5711 (TTY: 1-800-285-1131).

Patient/Family Member/Companion Signature	Date/Time
Signature of person, *if any*, who filled out this form on behalf of the patient, family member, or companion:	Date/Time
Witness	Date/Time

Patient Label