PATIENT REGISTRATION
PLEASE PRINT

PATIENT (Last, First): ______________________________ ☐ ☐ MALE FEMALE
TODAYS DATE____________

Previous Name ______________________________ ☐ ☐ SINGLE ☐ MARRIED
DIVORCED

ADDRESS: ____ HOME PHONE:
____

CITY: ________________________STATE: _____ ZIP CODE: _______CELL
PHONE:__________________________________

WORK PHONE________
____________EXT___________

BIRTHDATE: _________________________ AGE: _______ EMAIL:
____

REFERRED TO THIS OFFICE BY:
____

SOC. SEC. #:_XXX-XX-____________________________________PATIENT'S EMPLOYER:____
____

OCCUPATION: ____EMPLOYER PHONE
NUMBER:________________________

INSURANCE AND/OR INJURY INFORMATION

INSURANCE:____OTHER
INSURANCE:____________________________________

SUBSCRIBER'S NAME:________________________________SUBSCRIBER'S
NAME:___________________________________

ID #: ____ID #:
____

GROUP #: ____GROUP
#:____

PATIENT'S RELATION TO SUBSCRIBER: PATIENT'S RELATION TO
SUBSCRIBER:

☐ ☐ SELF ☐ SPOUSE ☐ CHILD DEPENDENT ☐ ☐ SELF ☐ SPOUSE ☐ CHILD
DEPENDENT

SUBSCRIBER'S EMPLOYER:
____
__

IF INJURED: DATE____________ PLACE: (circle one) HOME/ SCHOOL WORK AUTO
ACCIDENT OTHER_________

NATURE OR CAUSE OF
INJURY:____
______

IN CASE OF EMERGENCY- FRIEND OR RELATIVE TO BE NOTIFIED

NAME:____ RELATIONSHIP TO PATIENT:____________________________________

HOME PHONE:___________________________________ CELL PHONE:____

PHARMACY INFORMATION

NAME:____________________________________

ADDRESS:____

PHONE:___________________________________

FAX:____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT.

I hereby authorize my insurance benefits to be paid directly to the practitioner. I am financially responsible for any balance due. I also authorize the doctor and/or Insurance Company to release any information required for the claim. I acknowledge that I am responsible for all charges not covered by insurance, and that a cancellation fee will be charged if appointments are cancelled with less than 24 hours notice.

SIGNATURE:____

DOCTORS OF BELLEVUE-REDMOND, PLLC

15710 NE 24TH Street Ste C Bellevue WA 98007

P: 425-208-0026 F: 425-644-3868

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME: ____ DATE OF BIRTH: ______________________________

AUTHORIZE AND REQUEST YOU TO RELEASE A COPY OF MY MEDICAL RECORDS

TO:	FROM:
DOCTORS OF BELLEVUE-REDMOND, PLLC	Name: ________________________________
15710 NE 24th Street Ste C	Address: ________________________________
Bellevue WA 98007	City: _________________________ State: _________ Zip: _____

P: 425-208-0026	Phone: ____________________________
F: 425-644-3868	Fax: ______________________________

RELEASE FOLLOWING RECORDS:
__________ ALL HEALTH OF INFORMATION IN MY MEDICAL HISTORY
__________ SPECIFIC RECORDS RELATED TO THE FOLLOWING CONDITION:
____
__________ SPECIFICALLY EXCLUDE:
____

I hereby authorize and request that you release a copy of my medical records. This may include information about any tests/treatments relating to the sexually transmitted disease, HIV, mental health, drug and/or alcohol abuse, and/or illness, social work, or other protected information unless otherwise excluded.

Information will not be released without a valid signature below. This authorization is good for 90 days from the signature date and maybe revoked in writing at any time provided the information has not yet released.

PATIENT SIGNATURE ________________________________ DATE_______________

HIPAA NOTICE OF PRIVACY PRACTICES

We are required by law to make sure that information that identifies you is kept private, give you this notice of our legal duties and privacy practices with respect to your medical information and follow the terms of the notice that is currently in effect.
We understand that medical information about you is personal. We are committed to protect your medical information. We create a record of care and services you receive to provide quality care and to comply with legal requirements.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

For Treatment. We may use medical information about you to provide you with medical treatments or services. We may disclose medical information about you to doctors, nurses, technicians, or other health system personnel who are involved in taking care of you in the health system.

DOCTORS OF BELLEVUE-REDMOND, PLLC

15710 NE 24th Street Ste C Bellevue, WA 98008
Phone: 425-208-0026 Fax: 425-644-3868

Medical Appointment Cancellation Policy

Dear Patient:

We strive to render excellent medical care to you and the rest of our patients. In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:
We request that you please give our office a 24-hour notice in the event that you need to reschedule your appointment with the physician. This allows other patients to be scheduled into that appointment. It also makes it possible to reschedule your appointment more efficiently. If a patient misses an appointment without contacting our office, this is considered a missed appointment ("No Show, No Call"). A fee of $50.00 will be charged to you for a missed appointment. If a patient accumulates a total of three (3) missed appointments, the patient may not be rescheduled for future appointments and will be asked to leave the practice.

Additionally, if a patient is more than 15 minutes late to his/her appointment, the appointment may be cancelled.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Medical Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

______________________________	____________________
Printed Name of Patient	**Relationship to Patient**
______________________________	____________________
Signature of Patient of Responsible Party	**Date**

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or third party. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information about you to order healthcare facilities for purposes of payment as permitted by law.
For Health Care Operations. We may use and disclose medical information about you for operations of the Hospital and entities involved in an organized healthcare arrangement. We may also combine medical information about many patients to decide what services are not needed, and whether certain new treatments are effective. We may also disclose information about you to other healthcare facilities as permitted by law.
As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
We are not required to agree to your request. If we agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.
Uses and Disclosures of Protected Health Information Based upon Your Written Authorization . Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.
Complaints. If you are concerned that your privacy rights may have been violated, or if you disagree with a decision we made about access to your records, you may lodge a written complaint with our Office Manager.

Patient First, Last

Name:____

Patient Signature_____________________________________

Date_______________

Doctors of Bellevue-Redmond, PLLC

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to the success of your medical treatment and care. For your convenience we have answered a variety of commonly asked financial questions below. If you need further information, please ask to speak with the billing manager.

1. You will be asked to provide your insurance card (s) at every visit or if your insurance changed, please notify us. This is to ensure that the information we have is correct, and that your plan is current and in which we participate. Out of date cards with incorrect information or the wrong insurance cards can cause unnecessary delays in the payment of your plan. Frequently small changes (for example, a group number change or plan change) may not be considered significant by patients, but insurers will not process claims that are not 100% accurate.
2. We will submit insurance claims for our patients. However, the agreement of the insurance carried to pay for medical care is a contract between you and carrier. You should direct any questions and/or complaints regarding coverage to your insurance carried, your employed or to your agent. It is the responsibility of the patient to understand his/her medical benefits. There may be limitations and exclusions to coverage. Patients are responsible for any co-insurance, deductible and any other non-covered billable services. Please be aware that the balance of your claim is your responsibility. If you are self-pay it will cost $120.00 and follow up is $75.00
3. All office co-pays are to be paid at the time of service. **This is an insurance company policy.** We accept cash, credit/debit cards and checks.
4. Balance is due 30 days from when the bill is issued. Bills will be issued after the insurance carrier pays their portion. In addition to paying through mail, credit card information may also be called in to the billing office during business hours at 425-208-0026.

Patient Last, First Name

____

Signature

____

Date

____