OLYMPIC
INTERNAL MEDICINE, INC. P.S.

Frederick H. Dore, Jr., M.D. **M. Ryan Gross, M.D.**
Gary J. Gretch, M.D. **Michael B. Steele, M.D.**

Olympic Internal Medicine, Inc., P.S., 2620 Wheaton Way, Bremerton, WA 98310 (360)377-3923

Please use black ink only

A. Patient Information:

Name:_____ **Birthdate:** _____ **Sex:** ☐**M** ☐**F**

Address:_____
Mailing Address City State Zip Code

Phone:_____ ☐**Home** ☐**Work** ☐**Cell** ☐**Other** **Phone:**_____ ☐**Home** ☐**Work** ☐**Cell** ☐**Other**

Do we have your permission to leave medical information on your voice mail (Cell or Land Line)? I understand I will be responsible for any roaming or other phone plan fees. ☐**YES** ☐**NO**

Email: _____ **Occupation:** _____

Employer: _____ **Employer's Phone:**_____

Employer's Address: _____
Mailing Address City State Zip Code

Preferred Language: _____ **Ethnicity:** ☐**Hispanic or Latino** ☐**Non-Hispanic or Latino** ☐**Other/Undetermined**

Race: ☐**American Indian/ Alaskan Native** ☐**Black/ African American** ☐**Native Hawaiian / Pacific Islander** ☐**Asian** ☐**White** ☐**Declined to answer**

Marital Status: ☐**Single** ☐**Married** ☐**Widowed** ☐**Divorced** ☐**Separated**

Spouse's Name: _____ **Spouse's Phone:** _____

Preferred Pharmacy Name: _____ **Pharmacy Phone**: _____

B. If someone other than the PATIENT is responsible for payment, complete the following:

Relationship to the patient: _____ ☐**Same as patient**

Name:_____ **Address:**_____
Mailing Address City State Zip Code

Phone:_____ **Date of Birth:**_____

Employer: _____ **Address:** _____ **Phone:** _____
Mailing Address City Zip Code

C. In case of an EMERGENCY: (please list someone, who does not live with you, i.e. a neighbor or relative)

Name:_____ **Phone:**_____ **Relationship to patient** _____

DO YOU HAVE_____**A LIVING WILL**_____**DURABLE POWER OF ATTORNEY FOR HEALTH CARE? 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 against an individual.

Do you have any objection to our requesting your old medical records if deemed necessary? ☐**Yes** ☐**No**

NOTICE:
I consent to medical treatment and related services at Olympic Internal Medicine, Inc., P.S. We keep a record of the health care service we provide to you. You may ask us to see and copy that record. You may also ask us to correct that record. We will only disclose your record to others if you direct us to do so or if the law authorizes or compels us to do so. You may see your record, obtain copies of your record, or receive more information about your record at 2620 Wheaton Way, Bremerton, WA 98310.

Signature:_____**Date:**_____

INSURANCE INFORMATION

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How do you intend to pay? Cash_____ Check_____ Insurance_____ Other_____

Primary Insurance:_____

Subscriber:_____

BirthDate: _____

Relationship to Subscriber: _____

Insured ID: _____

Policy Group: _____

Insured Phone: _____

Company Name: _____

Effective Date: _____

Secondary Insurance:_____

Subscriber:_____

BirthDate: _____

Relationship to Subscriber: _____

Insured ID: _____

Policy Group: _____

Insured Phone: _____

Company Name: _____

Effective Date: _____

Is Medicare your secondary insurance? ☐YES ☐NO

MEDICARE PATIENTS ONLY:

Our office is a Medicare participating office. We will bill Medicare shortly after your office visit. All claims are assigned and payment will come directly to our providers. Please provide complete information if you have a "Medigap" insurance policy to Medicare as we will send this information to Medicare and bill this insurance directly. You will be responsible for the Part B deductible, co-payment if your secondary policy does not cover these charges and/or non-covered services by Medicare.

ASSIGNMENT OF BENEFITS - LIFETIME AUTHORIZATION

I request that payment of authorized MEDICARE benefits be made on my behalf to the practice for any services furnished to me by the providers of Olympic Internal Medicine, Inc., P.S. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Lifetime Signature of Medicare Beneficiary

OTHER INSURANCE: We will bill any insurance (up to two per patient) if you provide our office with your complete insurance information, including a copy of your insurance ID card(s).

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider indicated on the claim. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. A copy of this signature is as valid as the original.

_____

Signature of Patient

IF YOU HAVE HEALTH INSURANCE OF ANY KIND, WE WILL DO EVERYTHING WE CAN TO HELP YOU OBTAIN YOUR PAYMENT FROM YOUR INSURANCE CARRIER. HOWEVER, THE BASIC RESPONSIBILITY FOR PAYMENT IS YOURS.

Thank you for choosing our office!