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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

How do you intend to pay? Cash _____ Check _____ Insurance _____ Other _____

Primary Insurance: _____

Secondary Insurance: _____

Subscriber: _____

Subscriber: _____

BirthDate: _____

BirthDate: _____

Relationship to Subscriber: _____

Relationship to Subscriber: _____

Insured ID: _____

Insured ID: _____

Policy Group: _____

Policy Group: _____

Insured Phone: _____

Insured Phone: _____

Company Name: _____

Company Name: _____

Effective Date: _____

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!