

**REGISTRATION FORM**

PATIENT LABEL HERE

**Patient Information**

Last Name				First Name			MI	Alias or Maiden Name	
Date of Birth	Sex	Marital Status	Race	Social Security Number			Employer Name		
Street Address						City	State	Zip	
Home Phone				Work Phone <input type="checkbox"/> Patient <input type="checkbox"/> Mother <input type="checkbox"/> Father			Cell Phone <input type="checkbox"/> Patient <input type="checkbox"/> Mother <input type="checkbox"/> Father		
Email Address				Emergency Contact Name & Relationship			Emergency Contact Phone #		

**Responsible Party Information**

Last Name				First Name			MI	Alias or Maiden Name	
Date of Birth	Sex	Marital Status		Social Security Number			Relationship to the patient		
Street Address (if different from above)						City	State	Zip	
Home Phone				Work Phone <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian			Cell Phone <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian		
Email Address				Employer Name			Occupation		

**Insurance Information**

<b>Primary Insurance</b>									
Insurance Company Name				Group Number		Subscriber ID Number		Copay	
Subscribers Name				Social Security Number		Date of Birth		Relationship to the patient	
Subscribers Employer Name				Subscribers Home Phone			Subscribers Work Phone		
<b>Secondary Insurance</b>									
Insurance Company Name				Group Number		Subscriber ID Number		Copay	
Subscribers Name				Social Security Number		Date of Birth		Relationship to the patient	
Subscribers Employer Name				Subscribers Home Phone			Subscribers Work Phone		

**CONSENT TO CARE:**

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that Swedish participates in the training of physicians and other healthcare providers and I will be told when trainees take part in my care.

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Initial

**NOTIFICATION OF RELEASE FOR PAYMENT:**

I understand that the Swedish Physician Division will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

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**FINANCIAL AGREEMENT:**

I understand co-payments are due at the time of service. I assign payment from my insurance directly to the Swedish Physician Division. I understand I am financially responsible to the Swedish Physician Division for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills from the laboratory, radiology and other specialized services.

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**RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:**

I have received a copy of the Swedish Physician Division **Notice of Health Information Practices** which provides information about how my health information may be used and disclosed.

I have read the above and understand its contents:

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

- Data entered into Misys
- Insurance card scanned
- Drivers license/picture ID scanned

Parent or Guardian: \_\_\_\_\_