SWEDISH
MEDICAL GROUP

Patient Label Here

Baseline Testing Registration

Patient Information

Last Name		First Name			Middle Name
Alias or Maiden Name		Sex	Birth Date	Social Security Number	Marital Status
Street Address		City		State	Zip Code
Home Phone		Work Phone		Cell Phone	
Language	Interpreter YES / NO	Race	Ethnicity		Religion
Employer Name		Occupation		Employment Status Full Time / Part Time / Retired / Disabled / Not Employed	
Emergency Contact Name		Relationship		Phone Number(s)	
Primary Physician Name		Phone Number		City	

Person Responsible For Bill (If patient is under 18 years old)

Last Name		First Name	Middle Name	Relationship To Patient	
Alias or Maiden Name		Sex	Birth Date	Social Security Number	Marital Status
Street Address		City		State	Zip Code
Home Phone		Work Phone		Cell Phone	
Language	Interpreter YES / NO				
Employer Name		Occupation		Employment Status Full Time / Part Time / Retired / Disabled	

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.

NOTIFICATION OF RELEASE FOR PAYMENT: **Initial: _____**

I understand that the Swedish Medical Group 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.

FINANCIAL AGREEMENT: **Initial: _____**

I understand co-payments are due at the time of service. I assign payment from my insurance directly to the Swedish Medical Group. I understand I am financially responsible to the Swedish Medical Group 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.

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

I have received a copy of the Swedish Medical Group **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:

Patient Signature:_____ Date:_____

Parent or Guardian:_____ Date:_____