



REGISTRATION FORM

Patient Information

Form for Patient Information with fields: Last Name, First Name, Middle Name, Alias or Maiden Name, Date of Birth, Sex, Marital Status, Race, Religious pref, Social Security Number, Employer Name, Street Address, City, State, Zip, Home Phone, Work Phone, Cell Phone, Email Address, Emergency Contact Name & Relationship, Emergency Contact Phone #.

Guarantor

Form for Guarantor with fields: Last Name, First Name, Middle Name, Alias or Maiden Name, Date of Birth, Sex, Marital Status, Social Security Number, Relationship to the patient, Street Address, City, State, Zip, Home Phone, Work Phone, Cell Phone, Email Address, Employer Name, Occupation.

Insurance Information

Form for Insurance Information with sections: Primary Insurance (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) and Secondary Insurance (same fields).

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.

Initial

NOTIFICATION OF RELEASE FOR PAYMENT:

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.

Initial

FINANCIAL AGREEMENT:

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.

Initial

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES:

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:

Date: _____

Patient Signature: _____

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

Parent or Guardian: _____

