Western Washington Medical Group

Nutrition & Diabetes Education

Patient Registration

☐ New ☐ Update MRN_____

PATIENT LAST NAME	LEGAL FIRST NAME, MI	PREFERRED	SOCIAL SECURITY #	DATE OF BIRTH

SEX ASSIGNED AT BIRTH	GENDER IDENTITY: ☐ Genderqueer identifies as neither Male or Female	SEXUAL ORIENTATION ☐ Prefer not to disclose
☐ Male ☐ Female ☐ Other _____	☐ Identifies as Male ☐ Female-to-male ☐ Other _____ ☐ Identifies as Female ☐ Male-to-female ☐ Prefer not to disclose	☐ Heterosexual (straight) ☐ Bisexual ☐ Homosexual (gay/lesbian) ☐ Other _____

MAILING ADDRESS	APT #	CITY	STATE	ZIP CODE 4 DIGIT

HOME PHONE	WORK PHONE	EXT	CELL PHONE	PREFERRED EMAIL ADDRESS
( )	( )		( )	

PRONOUN	RACE	ETHNICITY	MARITAL STATUS
		☐ Hispanic ☐ Non-Hispanic	Married ☐ Single ☐ Divorced ☐ Widowed ☐ Seperated ☐ Other ☐

RELIGION	PREFERRED LANGUAGE	SPOKEN LANGUAGE	READING LANGUAGE	INTREPRETER NEEDED
				Yes ☐ No ☐

PATIENT EMPLOYER *REASON IF PATIENT IS NOT EMPLOYED: CHILD ☐ RETIRED ☐ DISABLED ☐*

EMPLOYER NAME	OCCUPATION

STREET ADDRESS	CITY	STATE	ZIP CODE	4 DIGIT

RESPONSIBLE PARTY *PERSON RESPONSIBLE FOR ANY REMAINING BALANCE*

☐ SELF (If self, sktip to next section)
☐ SPOUSE
☐ PARENT
☐ GUARDIAN

SOCIAL SECURITY #	LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	STATE	ZIP CODE	4 DIGIT

HOME PHONE	WORK OR CELL PHONE	EXT	DATE OF BIRTH	SEX
( )	( )			M ☐ F ☐ Other ☐

WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER	STATE OR SELF INSURED?

PRIMARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX	SUBSCRIBER'S ID #	GROUP NUMBER
	MALE ☐ FEMALE ☐ OTHER ☐		

SECONDARY INSURANCE

INSURANCE COMPANY NAME	RELATION TO SUBSCRIBER	COPAY

SUBSCRIBER'S NAME	SUBSCRIBERS EMPLOYER

SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBERS SEX	SUBSCRIBERS ID #	GROUP NUMBER
	MALE ☐ FEMALE ☐ OTHER ☐		

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge, additionally:
I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made.
I authorize the provider and clinic to release any information to process insurance claims.
I authorize my insurance claim to be paid directly to the clinic.
I authorize Western Washington Medical Group to leave voicemail messages if they are unable to reach me which may contain details of my medical condition.

_____ INITIALS

(_____) VOICEMAIL #

PATIENT SIGNATURE _____ ***DATE*** _____

Western Washington Medical Group

Acknowledgement of Receipt of

Notice of Privacy Practices

Name: _____ DOB: _____ MRN: _____

Registration Form Packet

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_____ _____

Signature of client (or personal representative) *Date*

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

_____ _____

Personal Representative's Name *Relationship to Client*

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

Other:_____

_____ _____

Employee Name *Date*

This form will be retained in your medical record.

Western Washington Medical Group

Registration Form Packet

Financial Agreement

Name: _____ DOB: _____ MRN: _____

We consider all patients as "private" unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for **"private"** patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care, it is the patient's responsibility to check their benefits prior to being seen. **Please be familiar with the benefits provided by your health plan.*

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service. If you are unable to pay your co-pay at time of service there may be an additional $15.00 fee charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, may be responsible for payments of interest on the unpaid balance of 9% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge **$35.00** for any NSF checks. (Per RCW 62.A-3-515 & 520.)

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the provider to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my provider.

No-Show/Late Cancellation Fee: All WWMG clinics require a minimum 24-hour notice of any appointment cancellations or reschedules, including telehealth appointments. Fees may vary by clinic, please contact your provider's office for details.

I **HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.**

Printed Name: _____ DOB: _____

Signature: _____ Date: _____

Western Washington Medical Group

Consent to Release Information

Name: _____ DOB: _____ MRN: _____

Consent to Release Information to Friends and Family

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. *(NOTE: if a specific topic box is not checked, we will be unable to discuss~ treatment related to that topic.)* WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:

☐ HIV (Aids virus)
☐ Sexually Transmitted Infections (STIs)
☐ Psychiatric disorders / mental health
☐ Alcohol / Substance abuse
☐ All other health information

Other: _____

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.

Please provide us with **YOUR** best, most current phone contact information. This information will become part of your permanent medical record *unless/until you change it.* You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you arc allowing us to leave sensitive health information and specifics related to referrals.

First phone number	**Second phone number**	**Third phone number**
_____	_____	_____
Check one: ☐ Cell ☐ Work ☐ Home	Check one: ☐ Cell ☐ Work ☐ Home	Check one: ☐ Cell ☐ Work ☐ Home
OK to leave detailed message?: ☐ Y ☐ N	*OK to leave detailed message?:* ☐ Y ☐ N	OK to leave detailed message': ☐ Y ☐ N

_____ _____
Signature of client (or personal representative) *Date*

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

_____ _____
Personal Representative's Name *Relationship to Client*

Western Washington Medical Group

Appointment Policy

Name: _____ DOB: _____ MRN: _____

A scheduled appointment is a commitment of time between the doctor and patient. We have reserved time just for you. When appointments are missed or canceled, that time is lost.

We ask that when you make an appointment you make every effort to keep that appointment. We understand that emergencies do arise, and we will take that into consideration. If you find that you cannot keep your scheduled appointment, we require two business days' notice so that we may see another patient in need of care.

It is office policy to charge a **$100.00** fee for any missed appointment without a minimum of 48 business hours' notice. This charge is your responsibility and insurance will not pay for missed office visits.

I certify that I have read the appointment policy and agree to abide by this policy.

Printed Name: _____ DOB: _____

Signature: _____ Date: _____