RAINIER
ORTHOPEDIC INSTITUTE
A Division of Proliance Surgeons, Inc., P.S.

PATIENT REGISTRATION

Please take the time to fill in all the blank spaces.
Use black or blue ink only

PATIENT INFORMATION

PATIENTS LAST NAME		FIRST	MI	PREFERRED NAME
AGE	BIRTHDATE / /	SEX	SOCIAL SECURITY NUMBER — —	
PHONE#	WK #	CELL#	EMAIL ADDRESS	
MAILING ADDRESS		CITY	STATE	ZIP
RACE	PREFERRED LANGUAGE		ETHNICITY	
EMPLOYER	OCCUPATION	SPOUSE'S NAME	PHONE#	

WHO SHOULD BE NOTIFIED OTHER THAN HUSBAND OR WIFE IN CASE OF EMERGENCY?

NAME	PHONE NUMBER	RELATIONSHIP

RESPONSIBLE PARTY: RESPONSIBLE FOR OBTAINING CURRENT AND UPDATED REFERRALS FROM FAMILY DOCTOR.

FULL NAME			HOME PHONE	SOCIAL SECURITY NUMBER — —
ADDRESS			EMPLOYER	
CITY	STATE	ZIP	BIRTHDATE / /	BUSINESS PHONE

INSURANCE INFORMATION - Please present your insurance card to the receptionist today.

Primary Insurance Plan: _____

Group Number: _____ ID Number: _____

Subscriber's Name: _____ D.O. B. _____ Employer: _____

Secondary Insurance Plan: _____

Group Number: _____ ID Number: _____

Subscriber's Name: _____ D.O. B. _____ Employer: _____

Name of Referring Physician: _____

IF DUE TO AN INJURY:

Date of Injury: _____ Time: _____ Where: _____

How Did This Happen? _____

Is this Due to an On the Job Injury? Yes / No If Yes, Name of Employer at Time of Accident: _____

Is there an Attorney Representing Your Injury? Yes / No If auto accident, what state? _____

Name of Attorney: _____ Phone Number: _____

[ ] I HAVE NO INSURANCE COVERAGE - PLEASE BILL ME DIRECT.

Signature: _____

PLEASE SIGN THE INSURANCE PAYMENT AUTHORIZATION ON THE BACK OF THIS SHEET

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize medical care for _____. I hereby authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for payment of all services according to the Proliance Surgeons Financial Agreement, regardless of any pending insurance claims. I authorize the physician to release any information necessary to the insurance company (ies) as listed above for the processing of claims.

I understand that my express consent is required for the medical provider to release any information in relation to the diagnosis and/or treatment of HIV (Aids virus), sexually transmitted disease, drug or alcohol abuse, psychiatric treatment or mental illness. If I have been treated or diagnosed in connection with any of the above listed conditions, you are specifically authorized to release to the above listed insurances all information or medical records relating to the diagnosis, testing or treatment.* Service charges will be added after 60 days.

Client assumes all responsibility for Collection fees, Collections costs, Attorney fees and Court costs.

Patient Signature: _____ Date _____

If a minor, by parent or guardian: _____ Date _____

*If the patient has reached his/her 14th birthday, ONLY the patient may authorize disclosure relating to sexually transmitted disease.

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to the Social Security Administration and Health Care Financing Administration or its intermediaries or carries any information necessary for this or a related Medicare / Medigap / other insurance claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

Regulations pertaining to Medicare assignment of benefits apply. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Regulations pertaining to Medicare assignment of benefits also apply

Patient Signature: _____ Date _____

PRIVACY POLICY

I have received a copy of the Proliance Surgeons privacy notice and Financial Responsibility Agreement.

Patient Signature: _____ Date _____