Lake Washington Pain Management

Date: ____________________

Patient Registration Form

Full Legal Name:		DOB:
Social Security #:		Sex: M F
Address:		
City:	State:	Zip:
Home Ph #	Cell Ph #	
May we leave protected health information via voice messages? Y N		
Occupation:	Employer:	
Referred by:	**Primary Care Doctor:**	

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:
Home Ph #	Cell Ph #
Name	Relationship to Patient:
Home Ph #	Cell Ph #

INSURANCE INFORMATION

Primary Insurance:	Plan Copay $
Subscriber ID:	Name of Insured:
Relationship to Insured:	Insured DOB:
Secondary Insurance	Plan Copay $
Subscriber ID:	Name of Insured:
Relationship to Insured:	Insured DOB:

Patient, Parent or Guardian Signature **Date**

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Patient Authorization Form

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

I authorize Advanced Pain Care to release my records and any information requested to the following individuals.

1. ______________________________ Relation to Patient: ______________________

2. ______________________________ Relation to Patient: ______________________

3. ______________________________ Relation to Patient: ______________________

4. ______________________________ Relation to Patient: ______________________

______________________________________ ________________________

Patient's Signature Date

LABOR AND INDUSTRIES / WORKERS COMPENSATION / AUTOMOBILE ACCIDENT / THIRD PARTY CLAIMS: Fill out the following information if you have an open claim or case -

____

Claim # ***Date of Injury***

____

Claims Manager Name *Claims Manager phone #*

I hereby authorize my insurance benefits to be paid directly to the healthcare provider as well as release of any information by provider or insurance company for this account.
Payment: I am financially responsible for any balance due. I agree to make payment arrangements on unpaid balances over 30 days old and all the reasonable expenses such as attorney fees and court costs should be account be referred to collections.

Signed: ____ Date: ______________________________