

WWMG Orthopedic, Sports and Hand Center

PLEASE PRINT

Patient Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Home Phone () _____ Work # () _____ Cell # () _____
Date of Birth _____ Sex _____ Marital Status _____
Social Security Number _____
Primary Care Doctor _____ Clinic _____
Referring Doctor _____ Clinic _____

PRIMARY INSURANCE

Insurance Company Name _____
Subscriber (Card Holder) _____ Employer _____
ID # _____ Group _____ Date of Birth _____
Social Security # _____ Sex _____ L&I Claim # _____ Date of Injury _____
Relation to Patient Self Spouse Parent/Guardian Other Co-Pay _____

SECONDARY INSURANCE

Insurance Company Name _____
Subscriber (Card Holder) _____ Employer _____
ID # _____ Group _____ Date of Birth _____
Social Security # _____ Sex _____ L&I Claim # _____ Date of Injury _____
Relation to Patient Self Spouse Parent/Guardian Other Co-Pay _____

RESPONSIBLE PARTY Who is responsible for the remaining balance on this account?

Self Parent Guardian Name _____ SS# _____
Date of Birth _____ Sex _____ Home # () _____ Work # () _____
Address _____ City _____ State _____ Zip _____
Emergency Contact _____ Phone () _____ Relationship _____

How did you hear about us? Yellow Pages Primary Care Physician Friend/Relative

Signature _____ Date _____ (over)



Authorizations and Acknowledgements

Acknowledgement of Receipt of Notice of Privacy Practices

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

Patient or Guardian Signature

Date

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

Person Representative Name _____

Relationship _____

Consent for Verbal Communication

I give the physicians and office staff of Western Washington Medical Group, Department of Orthopedics permission to discuss my medical condition with the people listed below; I understand that anyone not listed and requests ANY information in my behalf, WWMG will not disclose information of any kind.

Name

Relationship

Phone Number

Name

Relationship

Phone Number

Financial Agreement

We consider all patients as “private” unless their insurance is one with whom we have contractual agreements. 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 only a certain percentage of the fees charged. The insurance normally covers the usual and customary fees. Your insurance, as a result may cover less than you had anticipated or you may have a deductible to meet first. We strongly suggest for you to contact your insurance for benefits and specific information.

If you do not have insurance we do request \$ 200.00 deposit for each office visit paid at time of service. There will be a \$ 25.00 charge for Non-Sufficient fund check returned. There may be a \$ 25.00 charge for not giving a 24 hour notice when cancelling an appointment or not arriving for a scheduled appointment.

There may be a \$ 25.00 charge if Co-Pays are not paid at time of service.

Do You Need a Referral?

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is a patient’s responsibility to see that your health plan requirements are met. If your insurance information or other required documents are not provided, any charges incurred will be your responsibility. We strongly suggest you contact your insurance to ensure appropriate referrals and authorizations have been obtained before each office visit or surgical need.

I have read the financial agreement, understand and agree to this policy

Patient or Guardian Signature

Date