Patient Registration

Lauren Schweizer and Staff welcome you to Bothell Women's Health!
*To help us meet your healthcare needs, please fill out this form completely in **dark ink**.*

Patient Information:

Name:_____ M☐ F☐ Birthdate:____/____/_____
(LAST) (FIRST) (MI)

Home Address:_____City:_____ State:____Zip:_____

Social Security# (required for Medicare)_____-____-_____ Preferred Phone #:(_____)_____

We strongly recommend our patients sign up for our online portal so they may have access to their lab results. Please provide your email below and you will receive an email invite from Patient Fusion to set up your account.

Email:_____

Emergency Contact Person:

Name:_____Phone # (_____)_____

Primary Insurance Coverage For The Patient:

Insurance Company:_____Co-pay Amount: $____

Subscriber Name:_____ **Subscriber's DOB**:___/___/_____
(LAST) (FIRST) (MI)
Relationship to Patient: _____Subscriber ID#_____Plan/Group #_____

Address to send medical claims: _____

Secondary Insurance Coverage For The Patient (if applicable):

Insurance Company:_____Co-pay Amount: $____

Subscriber Name:_____ **Subscriber's DOB:__/___/_____**
(LAST) (FIRST) (MI)
Relationship to Patient: _____Subscriber ID#_____Plan/Group #_____

Address to send medical claims: _____

Authorization For Treatment and Financial Agreement:
The above information is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made. I authorize Bothell Women's Health to release any information to process insurance claims. I also authorize my insurance to be paid directly to the clinic. The undersigned agrees that whether she signs as an agent that she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, will be responsible for the payment of interest on the unpaid balance at 1% per month from the date of service. I have also been informed of the $50 fee (per RCW 62A.3-515 & 520) on checks returned NSF.

Notice of Cancellation/No Show Policy:
Due to a large number of same day cancellations and "no shows" our policy is as follows: Any client who fails to keep their scheduled appointment OR cancels their appointment with less than 24 hours advance notice to the clinic will be charged a $75 fee to their account. This policy is in place to maximize access to services for clients. When a client cancels an appointment with enough notice (as specified above) it allows us to offer this appointment time to another client who is in need of health care services.

Patient Signature:_____ Date:___/___/____