Patient Registration

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

Home Address:_____City:_____ State:_____Zip:_____

Social Security# _____-____-_____ (Required if Tricare) **Preferred** Phone #:(_____)_____ ☐**CELL** ☐**HOME**

PREFERRED PHARMACY: _____
(Name) (City) (Phone)

EMAIL:_____

We strongly recommend our patients sign up for our online portal PatientFusion.com so they may have access to their lab results, medications, and plan of care. This also allows you to communicate with our staff regarding any questions concerning your health. Please provide your email and you will receive an email invite to set up your account. Our business email is not a secure email and can only be used for business purposes.

Emergency Contact Person:

Name:_____Phone # (_____)_____ Relationship: _____

Primary Insurance Coverage For The Patient: ☐**CASH PAY/ NO INSURANCE**

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:

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. I authorize Bothell Women's Health to release any information to process insurance claims. I also authorize my insurance claims 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 can be made to the clinic but must be verbally agreed upon before the 30 days is expired. I have also been informed of the $20 fee (per RCW 62A.3-515 & 520) on checks returned NSF.

Patient Signature:_____ Date:_____/_____/_____