Patient Registration Form

Patient Label or MRN

MINOR & JAMES MEDICAL

SWEDISH Health Partner

PATIENT INFORMATION

Name (Last, First Middle) | Alias/Maiden

Birthdate / / | Soc Sec #: -- -- | ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Address | Skilled Nursing Facility? ☐ | Apt | City | State | Zip

Primary Phone | Work Phone | Other Phone

☐ African American ☐ Caucasian ☐ Other: ☐ Asian ☐ Hispanic ☐ Native American/Inuit ☐ Pacific Islander ☐ Decline

Religion (specific to medical needs or requirements): None ☐

☐ Needs interpreter Language:

Primary Care Physician:

Employer | Occupation | ☐ Retired | Emergency Contact | Phone | Relationship

BILLING & INSURANCE INFORMATION

Guarantor (person responsible for bill) Same as patient ☐

Name (Last, First Middle) | Alias/Maiden

Birthdate / / | Soc Sec #: -- -- | ☐ Male ☐ Female | Relationship to patient

Address | Apt | City | State | Zip

Employer | Occupation | ☐ Retired | Primary Phone | Alternate Phone

Primary Insurance | Provider:

Group: | ID:

Subscriber: | Same as patient ☐

Birthdate / / | Copay(s)

Soc Sec #: -- --

Employer | ☐ Retired | Relationship to patient

Secondary Insurance | Provider:

Group: | ID:

Subscriber: | Same as patient ☐

Birthdate / / | Copay(s)

Soc Sec #: -- --

Employer | ☐ Retired | Relationship to patient

INITIALS: _____

CONSENT TO CARE: I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known.

INITIALS: _____

NOTIFICATION OF RELEASE FOR PAYMENT: I understand that Minor & James Medical will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies and any liable third party payers. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment for HIV/AIDS, sexually transmitted diseases, substance abuse or mental health conditions.

INITIALS: _____

FINANCIAL AGREEMENT: I understand co-payments are due at the time of service. I assign payment from my insurance directly to Minor & James Medical. I understand I am financially responsible to Minor & James Medical for the charges not paid by insurance and that those charges are due within 30 days of invoice. I understand that in addition to the bill from my provider I may also receive separate bills from the laboratory, radiology and other specialized services. If co-pays are not collected at the time of service, MJM may charge a $10 billing/administrative fee.

INITIALS: _____

RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES: I have received a copy of the Minor & James Notice of Health Information Practices which provides information about how my health information may be used and disclosed.

Signature ☐ Signed by patient ☐ Signed by parent/guardian

Printed name of parent/guardian

Date

Relationship to patient

SEE OTHER SIDE ▶

MEDICARE ELIGIBILITY INFORMATION

Medicare Patients: In order to process your claim properly, Medicare requires us to gather information regarding your current Medicare eligibility. We will need to verify this information with you every 90 days. Please answer the following questions:

Medicare #: ☐ **Part A Date:** / / ☐ **Part B Date:** / /	**YES**	**NO**
Are you over 65 years of age and is this why you have Medicare Part B benefits?	☐	☐
Are you employed right now?	☐	☐
Is your spouse employed right now?	☐	☐
Are you covered by a health plan from your own or family member's current employment?	☐	☐
Does the employer have 20 or more employees?	☐	☐
Are you or your spouse retired? Your retirement date: / /	☐	☐
Spouse's name: _____ Spouse's retirement date: / /		
Do you have Medicare because of end stage renal disease (ESRD)?	☐	☐
Is ESRD the reason you first became eligible for Medicare?	☐	☐
Are you within the first 30 months of treatment for ESRD?	☐	☐
Is the reason you have Medicare due to a disability, other than ESRD?	☐	☐
Are you covered by a group health plan of an employer with over 100 employees?	☐	☐
Has the Department of Veterans Affairs (VA) authorized and agreed to pay for the services at this facility today? *VA benefits are separate from TRICARE medical coverage. "Yes" means the VA sent you here today.*	☐	☐
Were you a coal miner and entitled to benefits under the Federal Black Lung Program?	☐	☐
Is this illness or injury due to a work related accident, and will your bill today be sent to a Workers' Compensation Carrier primary to or instead of Medicare	☐	☐
Is this illness or injury the result of a non-work related accident (i.e. motor vehicle accident)?	☐	☐
Do you have non-fault or liability insurance (i.e. auto insurance) that we should bill instead of Medicare for your services today?	☐	☐
Are services to be paid by a government research program? *If yes, please provide billing instructions to the front desk.*	☐	☐

ACCIDENT/INJURY

Claim Info — **CLAIM OR POLICY #:**

Employer/Auto Insurance Company Name or State L&I

Claim Address

City State Zip

☐ Claim Manager Assigned

Name

Phone

☐ Attorney Involved

Name

Phone

This claim is older than 3 months? ☐ Yes ☐ No **I have PIP Coverage?** ☐ Yes ☐ No

Injury Info

Date of Injury / /

Time of Injury : ☐ AM ☐ PM

Injured body part:

Place of injury ☐ Home ☐ Work ☐ Other

Address

City County State Zip

☐ Work-related accident/illness (L&I)

Company Name

☐ Motor vehicle accident (MVA)

☐ Crime Victim ☐ Other

Name/Clinic of referring physician (☐ I have been treated by this doctor for this injury?) Phone