

Patient Registration

Appt Date:

Patient Profile

Social Security Number: _____

First Name: _____

Last Name: _____

Responsible Party if Minor: _____

Relationship: _____

Mailing Address : _____

City: _____

State: _____

Zipcode: _____

Home Phone: _____

Mobile Phone: _____

Employer: _____

Work Phone: _____

Date Of Birth: _____

Gender: _____

Referring Physician: _____

Name of Insurance: _____

Policy #: _____

L&I Claim Number: _____

Employer at TOI and DOI: _____

SID Carrier and Claim #: _____

Financial Agreement and Authorization for Treatment:

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect any unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper. I agree that the venue for any legal action shall be Thurston County.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.) **I understand that if I am not eligible under the terms of my Medical and Hospital subscriber agreement, or if my exam has not been properly authorized by my PCP and/or insurance company prior to my appointment date, I am liable for all services rendered.**

I authorize Grays Harbor Imaging or South Sound Radiology to bill my insurance carrier and that the payment will be sent directly to the provider.

I understand it is my sole responsibility to check eligibility and coverage issues with my insurance carrier. Grays Harbor Imaging or South Sound Radiology staff cannot determine eligibility and coverage issues for insurance plans.

THIRD PARTY AUTO INSURANCE CASES ARE THE PATIENT'S RESPONSIBILITY. WE DO NOT WAIT FOR SETTLEMENT.

The above information is for the purpose of obtaining credit and it warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification.

SIGNATURE OF RESPONSIBLE PARTY:

Print Name _____ Signature _____ Date _____