Grove Street Family Clinic

Grove Street Family Clinic
1630 Grove Street
Marysville, WA. 98270
(360) 653-3500 fax (360) 657-3268

NEW PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

LAST NAME OF PATIENT	FIRST NAME	MI	☐ MALE ☐ FEMALE	AGE
ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE ( )	WORK PHONE ( )	DATE OF BIRTH	SOCIAL SECURITY NO.	EMPLOYER	YEARS
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE	WHO WILL BE PAYING THE BILL? ☐ SELF ☐ OTHER	☐ MARRIED ☐ SINGLE

RESPONSIBLE PARTY OR INSURANCE SUBSCRIBER

LAST NAME OF RESPONSIBLE PARTY	FIRST NAME	MI	☐ MALE ☐ FEMALE
ADDRESS (☐ SAME AS PATIENT)	CITY	STATE	ZIP CODE
HOME PHONE ( )	WORK PHONE ( )	DATE OF BIRTH	SOCIAL SECURITY NO.	EMPLOYER	YEARS
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT

IN CASE OF EMERGENCY NOTIFY

LAST NAME	FIRST NAME	PHONE ( )	ADDRESS

MEDICAL INSURANCE COMPANY INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	GROUP #	ID#
ADDRESS	CITY	STATE	ZIP	PHONE
NAME OF SECONDARY INSURANCE COMPANY	GROUP #	ID#
ADDRESS	CITY	STATE	ZIP	PHONE

MEDICAL INFORMATION

REASON FOR TODAY'S VISIT	-OPTIONAL- E-MAIL ADDRESS

LIST ANY ALLERGIES
(INCLUDING FOOD & MEDICATION)

LIST ANY HOSPITALIZATIONS
SURGERIES OR MAJOR INJURIES (INCLUDE DATES)

LIST ANY MEDICATIONS
CURRENTLY BEING TAKEN

HOW DID YOU HEAR ABOUT OUR CLINIC

FAMILY HISTORY:
KIDNEY DISEASE ☐ EYE DISEASE ☐ LUNG DISEASE ☐ HEART DISEASE ☐ DRUG ALLERGIES ☐ HIGH BLOOD PRESSURE ☐

DIABETES ☐ CANCER ☐ TYPE OTHER INFO

PAYMENT OF BENEFITS

I understand that Grove Street Family Clinic will bill my insurance if I have provided adequate information (ID and Insurance card). I authorize payment of benefits by my insurance company directly to Grove Street Family Clinic. I agree that after 60 days all balances due become my responsibility regardless of insurance coverage. I also agree that all charges not paid by my insurance company will be my responsibility.

Terms

If no insurance coverage, full payment is required at time of service.

There will be a rebilling fee on any balance over 30 days. The rebilling fee is 1% or a minimum of $3.00 per month. There will be a $35.00 charge on any checks returned by your bank. The Grove Street Family Clinic reserves the right to change the terms/fees without notice

Medical Release Authorization

- Insured party or dependent patient, if not a minor, must sign for all claims.
- I authorize any insurance company, organization, employer, hospital, or health care provider to release any information requested with regard to processing my claim.
- I certify that the information I furnish is true and correct.
- I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

No Show Policy

A $25.00 "No- Show" fee will be charged for failing to show up on time for a scheduled appointment without cancelling at least 24 hours in advance. Additionally, future appointments cannot be scheduled until the "No-Show" fee is paid.

I CERTIFY THAT THE INFORMATION I FURNISH IS TRUE AND CORRECT, AND THAT I HAVE READ, UNDERSTAND AND AGREE TO THE POLICIES AND TERMS OUTLINED ABOVE.	SIGNATURE	PRINTED NAME	DATE

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

This Consent was signed by: _____

Printed Name - Patient or Representative

_____ _____ / / _____

Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____

Printed Name - Patient or Representative

_____ _____ / / _____

Signature Date