PATIENT INFORMATION SHEET

Ms/Mrs./Miss/Mr.
PATIENTS NAME: _____ __
FIRST **M.I.** **LAST**

(Mail) Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Birth date: _____ _____ **( ) Male ( ) Female** **Social Security:** _____

Employer: _____ **Business Phone: ( )** _____

Patients Spouse or Partner's Name: _____

Employer: _____ **Phone #: ( )** _____

EMERGENCY CONTACT: (person we may contact in case of an emergency not living in your household):

_____
Name Relationship Phone Number

REFERRED BY: _____
LAST NAME FIRST NAME PHONE NUMBER

_____
STREET ADDRESS CITY, STATE FAX NUMBER

PRIMARY PHYSICIAN: _____
LAST NAME FIRST NAME PHONE NUMBER

_____
STREET ADDRESS CITY, STATE FAX NUMBER

Cardiologist: _____

Pharmacy Name/Phone Number: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Subscriber Name: _____

Subscriber date of birth: _____ Relationship to patient: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber date of birth: _____ Relationship to patient: _____

PLEASE READ THE FOLLOWING CAREFULLY

Assignment, Release and Financial Agreement: I authorize treatment to the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize the physician to release any information required. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I am financially responsible for account payment. A billing fee of up to $50 on past due accounts over 90 days will be charged. Balances over 30 days may incur an interest charge of 1% per month, 12% APR (RCW19.52). I have also been informed of the $40 fee (per RCW62A2-515 & 520) on checks returned to NSF. In the event it should become necessary to place for collection an unpaid balance due for services rendered to me or my family, I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney fees, filing costs and any other costs the court determines proper.

_____ _____
Patient Signature Date