WESTERN WASHINGTON MEDICAL GROUP
Family Practice

REGISTRATION FORM

Patient Last Name:	Patient First Name:	MI:	Preferred or Nickname:	Pronouns: __ He/Him __ She/Her __ They/Them

Date of Birth:	Race: Ethnicity:	Preferred Language: Social Security #:	Marital Status: __ Married __ Divorced __ Other __ Single __ Widowed __ Separated

Gender at Birth: M F	Gender Identity: __ Identifies as Male __ Female to male __ Identifies as Female __ Male to female __ Other:__________ __ Choose not to disclose	Sexual Orientation: __ Choose not to disclose __ Heterosexual (straight) __ Bisexual __ Homosexual (gay/lesbian) __ Other: __________

Mailing Address:	Apt #	City:	State:	Zip Code:
Street Address:	Apt #	City:	State:	Zip Code:

Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )	Email Address:

Primary Care Provider:	Patient Occupation:	Employer Name:

INSURANCE INFORMATION

Primary Insurance Information	**Secondary Insurance Information (if applicable)**
Insurance Company:	Insurance Company:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Gender: _____ Male ____ Female ___ Other	Subscriber Gender: _____ Male ____ Female ___ Other
Member ID #:	Member ID #:
Group Number:	Group Number:
Copay:	Copay:

Emergency Contact:	Relationship:	Phone #:

RESPONSIBLE PARTY

Parent or guardian information responsible for the remaining balance on this account

__ Self (if self no need to fill out next section) __ Spouse __ Parent __ Guardian	Social Security #:	Last Name:	First Name:	MI:
	Address:	City:	State:	Zip Code:
	Phone #:	Date of Birth:	Gender: __ M __ F __ Other	

How did you hear about us?

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the provider and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic.

Patient/Guardian Signature: ______________________________________ Date: ____/____/____

NEW PATIENT INFORMATION

Date of service: _____/_____/_____

Name: ______________________ Age: ______ Date of birth: _____/_____/_____ Gender: M / F

Preferred pharmacy: ______________________ Allergies to any medications, X-ray die, or other: Yes / No

If yes, which substance and type of reaction: ______________________

CURRENT MEDICATIONS AND SUPPLEMENTS

Name:	Dose:	Frequency:

FAMILY HISTORY OF ILLNESS

Alzheimer's	Yes / No	Mother / Father	
Parkinson's	Yes / No	Mother / Father	
Cancer	Yes / No	Mother / Father	Type: ______________
Heart disease	Yes / No	Mother / Father	
Diabetes	Yes / No	Mother / Father	Type: ______________
Stroke	Yes / No	Mother / Father	
Hypertension	Yes / No	Mother / Father	
Alcoholism	Yes / No	Mother / Father	
Bleeding disorder	Yes / No	Mother / Father	
Mental illness	Yes / No	Mother / Father	Type: ______________

SOCIAL HISTORY

Do you consume (circle all that apply): coffee / tea / energy drinks / alcohol / tobacco / vape / marijuana

If any, which one(s) and daily amount: ______________________

____

OPERATIONS AND HOSPITALIZATIONS

Reason:	Date:	Place:	Provider:

Western Washington
Medical Group

Registration Packet

Financial Agreement

We consider all patients as **"private"** unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for "private" patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care, it is the patient's responsibility to check their benefits prior to being seen.
*Please, be familiar with the benefits provided by your health plan.

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is YOUR responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Accounts that are past due with no response to billed invoices must call our billing department to coordinate payments ASAP; otherwise the patient may be terminated from the practice, and may suffer financial penalties and/or be sent to collections.

Co-pays are due at time of service, if you are unable to pay your co-pay at time of service there may be an additional $15.00 fee charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, may be responsible for payments of interest on the unpaid balance of 9% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge $35.00 for any NSF checks. (per RCW 62A-3-515 & 520)

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the provider to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my provider.

No-Show/Late Cancellation Fee: All WWMG clinics require a minimum 24-hour notice of any appointment cancellations or reschedules, including telehealth appointments. No show appointments will be charged $50-75. After 3 no show appointments and/or late cancellations (with less than a full 24hn notice to our clinic), you will be asked to leave the practice.
Missed appointments take up valuable time.

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name ____________________________ DOB ____________________________

Signature ____________________________ Date ____________________________

Western Washington
Medical Group

Registration Packet

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I, ______________________________, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

____ ________________________

Signature of client (or personal representative) *Date*

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

____ ________________________

Personal Representatives Name Relationship to Client

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign
[ ] Communications barriers prohibited obtaining the acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
Other: ____

____ ________________________

Employee Name *Date*

This form will be retained in your medical record

Western Washington
Medical Group

Registration Packet

Consent to Release Information to Friends and Family

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. *(NOTE: if a specific topic box is not checked, we will be unable to discuss any treatment related to that topic.)*

WWMG MAY DISCLOSE HEALTH CARE INFORMATION REGARDING TESTING, DIAGNOSIS AND TREAMTMENT FOR THE FOLLOWING CONDITIONS:

[ ] HIV (Aids virus)
[ ] Psychiatric disorders / Mental health
[ ] All other health information
[ ] Sexually Transmitted Infections (STIs)
[ ] Alcohol / Substance abuse

Other: ____

The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over.

Name ______________________ Relationship__________________ Phone ___________________

Name ______________________ Relationship__________________ Phone ___________________

Name ______________________ Relationship__________________ Phone ___________________

Patient's Personal Phone Information: NOTE! This is DIFFERENT than the above info.

Please provide us with YOUR best, most current phone contact information. This information will become part of your permanent medical record *unless/until you change it*. You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First Phone Number

____

Check one: Cell Work Home
Ok to leave detailed message?: Y N

Second Phone Number

____

Check one: Cell Work Home
Ok to leave detailed message?: Y N

____ ____________________

Signature of client (or personal representative) *Date*

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

____ ____________________

Personal Representative's Name *Relationship to Client*