Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Sleep Medicine as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize Sleep Medicine to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize Sleep Medicine to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Sleep Medicine does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X__________________________________________________

(Patient or Parent/Guardian if under 18 years of age)

Relationship of Guardian

______________________________

Date

______________________________
PATIENT INFORMATION - PLEASE PRINT

SOC SEC #: ______________-_____________-_______________          MRN#:___________________

Name: ________________________________________________  Home Phone: _____________________________

   Last     First         Mid Initial

Address: ______________________________________________  Work Phone: ___________________ Ext:_______

City: __________________________________________________  Cell Phone: _____________________________

State: _________________ Zip Code: ______________________

SEX:  ☐ Male  ☐ Female

WORK PHONE: ___________________Ext:_______

DATE OF BIRTH: ______-____-______ Age: _____yrs

EMPLOYER: _________________________________________

WORK ADDRESS: _________________________

MARITAL STATUS:  ☐ Married   ☐ Single    ☐ Divorced

   ☐ Partner  ☐ Widowed   ☐ Separated

Occupation: _________________________________________

EMAIL:_________________________@_________

PRIMARY CARE PHYSICIAN: _________________________________________

REFERRAL

Who referred you to our clinic? (PLEASE CHECK BOX)

☐ Washington Regional Medical Center  ☐ Community or Company Health Fair  ☐ Referred by a Physician:___________________________

☐ Newspaper or Magazine  ☐ Treated by Physician in hospital  ☐ Employer

☐ Recommended by friend or family member  ☐ Internet  ☐ Insurance Plan Directory

☐ Drove by Location of Clinic  ☐ Phone Directory (Yellow pages)  ☐ Return Patient/ Not Applicable

☐ Other: ____________________________

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _________________________________  Cell: _____________________________________

Employer: ___________________________________________  Work: ___________________ Ext: _____________

Work Address: _________________________________________  Spouse/Parent SEX:  ☐ Male  ☐ Female

City: __________________ State: ________ Zip: __________  Spouse/Parent Date of Birth: _____/_____/_____  Social Sec. #: __________-_______-___________

Occupation: _________________________________________

EMERGENCY CONTACT INFORMATION

Emergency contact: _________________________________  Cell Phone: ________________________________

Address: __________________________________________  Home Phone: ______________________________

City: __________________ State: _____ Zip: _______  Relationship to Patient: ____________________________
PRIMARY INSURANCE

Patient’s Relationship to Main Policy Holder: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: ____________________________

Name of Insurance Company: _____________________________________________________________________________

Insurance Company Address: _____________________________________________________________________________

City: __________________________ State: __________________________ Zip: __________________________

ID# __________________________ Group # __________________________

Insurance Company’s Phone Number: ________________________________________________________________

Main Holder’s Name: __________________________________  Main Holder’s Date of Birth: _____/_____/______

Main Holder’s Address: ________________________________   Main Holder’s Soc Sec#: _______-______-______

City: ________________________________________________

State: __________________________ Zip: __________________________

SECONDARY INSURANCE

Patient’s Relationship to Main Policy Holder: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: ____________________________

Name of Insurance Company: _____________________________________________________________________________

Insurance Company Address: _____________________________________________________________________________

City: __________________________ State: __________________________ Zip: __________________________

ID# __________________________ Group # __________________________

Insurance Company’s Phone Number: ________________________________________________________________

Main Holder’s Name: __________________________________  Main Holder’s Date of Birth: _____/_____/______

Main Holder’s Address: ________________________________   Main Holder’s Soc Sec#: _______-______-______

City: ________________________________________________

State: __________________________ Zip: __________________________
GENERAL INFORMATION
Who is responsible for Payment?:  □ Myself  □ Other: __________________________ (FILL OUT BELOW)

Responsible Party Name: __________________________  Responsible Party DOB: ______/_____/_____

Relationship to Patient:  □ Self  □ Spouse  □ Child  □ OTHER  SS#____________-_______-__________

Address: __________________________________________  Phone#: __________________________

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics?  □ Yes  □ No

If Yes, When?: ______/_____/______  Where?: __________________________

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: __________________________________________  Relation to Patient: __________________________

Name: __________________________________________  Relation to Patient: __________________________

Name: __________________________________________  Relation to Patient: __________________________

Preferred Language:  □ English  □ Spanish  □ Marshallese  □ Arabic  □ DECLINE  OTHER: ______________________

Race:  □ White  □ African American  □ Asian  □ Native Hawaiian/Other Pacific Islander

□ Native American Indian/ Alaskan  □ Hispanic  □ Unknown  □ DECLINE

Ethnicity (Origin):  □ Not Hispanic or Latino  □ Hispanic or Latino  □ Unknown  □ DECLINE

Preferred Communication Method:  □ Print  □ Save to Flash Drive  □ DECLINE

Wellness Reminders:  □ Mail  □ Cell Phone  □ Home phone  □ Work Phone  □ DECLINE

PREFERRED PHARMACY: __________________________  LOCATION: __________________________

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I authorize WRMC operators in their role as an answering service to release my protected health information utilizing the pager system or text messaging. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X___________________________________________________ Date: _________/__________/________

Signature (Patient or Parent/Guardian if minor)