Care Medical Group
& Care Medical Group Physical Therapy
Patient Registration

Please use black ink pen only.

Patient Personal Information

Patient's Name: ______________________________
First M.I. Last

Mailing Address: ______________________________
Street Apt. #

____
City State Zip

Phone #: ______________ Cell / Home / Work Secondary #: ______________ Cell / Home / Work

Date of Birth: ______________ Social Security #: ______________

Gender: M F Employer: ______________

Marital Status: ______________ Spouse's Name: ______________

Spouse's Employer: ______________ Spouse's Work #: ______________

Do you have any food/drug allergies or reactions?: ______________

In case of emergency, whom should we contact *outside of your household*?: Name: ______________

Relation to patient: ______________ Phone #: ______________ Cell / Home / Work

Home Address: ______________________________
Street Apt. #

____
City State Zip

I authorize the person named below to discuss treatment and/or medications on my behalf (OPTIONAL):

Name: ______________ Relation to patient: ______________

General Information

How did you hear about us?: ______________

Do you have a primary care doctor?: Y___ N___ Name of doctor: ______________

Notice of Privacy Practices

I acknowledge receiving the Notice of Privacy Practices for Care Medical Group.

Printed Name: ______________ Signature: ______________

Relation to patient (if not self): ______________ Date: ______________

4280 Meridian #120 • Bellingham, WA 98226 • Tel 360.734.4300 • Fax 360.734.2128

Care Medical Group

& Care Medical Group Physical Therapy

Patient Registration

Insurance Information

Do you have medical health insurance?: Y____ N____

If yes, is your primary or secondary insurance coverage Medicare?: Y____ N ____

Name of Primary Insurance Company: ______________________________

ID #: ______________________ Group #: __________ Copay: $ __________

Policyholder's Name: ______________________ (First / Last) Relation to Patient:__________

Policyholder's Date of Birth (if not self): __________________ Phone #: __________

Policyholder's Address (if not self): ______________________________ (Street / City / State / Zip)

Name of Secondary Insurance Company: ______________________________

ID number: ______________________ Group number: __________

Policyholder's Name: ______________________ (First / Last) Relation to Patient:__________

Policyholder's Date of Birth (if not self): __________________ Phone #: __________

Policyholder's Address (if not self): ______________________________ (Street / City / State / Zip)

Payment and Credit Policies

Payments are accepted in the form of cash, Visa or MasterCard only. **No checks are accepted**.

Self-pay patients are expected to make full payment at the time of service. If we are a preferred provider for your insurance company and your coverage has been verified, then the applicable copayment and/or deductible is expected at the time of service. It is your responsibility to know your insurance coverage policies regarding all services rendered.

I request that payment of authorized INSURANCE COMPANY benefits be made on my behalf to Care Medical Group. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and/or any other INSURANCE COMPANY any information needed to determine these benefits or the benefits payable for related services.

I have carefully read these payment and credit policies. I accept full responsibility, on the terms and conditions stated herein, for payment of services rendered and charges incurred regardless of third party (insurance company) involvement. I understand and accept that a rebilling fee and/or a finance charge of 1.0% per month (minimum $5.00 charge) may be applied to any overdue balance, and in the event of non payment, I will bear the cost of collection and/or court fees and reasonable attorney fees should this be required.

Signature: ______________________ **Date:** ______________

4280 Meridian #120 • Bellingham, WA 98226 • Tel 360.734.4300 • Fax 360.734.2128