Care Medical Group
& Care Medical Group Physical Therapy

Patient Registration

*** = Required Fields**

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

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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:** ____________________

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Care Medical Group

No-Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows delay the delivery of health care to other patients, some who are quite ill.

A "no-show" is missing a scheduled appointment; a "late cancellation" is cancelling an appointment on the same day that it is scheduled.

Please give at least one business days' notice if you cannot make your scheduled appointment. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A charge of $35 will be assessed for each no-show office visit and/or procedure appointment.

Please understand that insurance companies, including worker's compensation insurance, consider this charge to be entirely the patient's responsibility.

____
Date

____
Signature

____
Birth Date

____
Printed Name of Patient

____
Printed Name if Signed on Behalf of Patient

Care Medical Group
4280 Meridian Street, Ste 120 ~ Bellingham WA 98226

Explanation of Wait Times

Care Medical Group has four distinct departments:

- **Urgent Care**
- **Family Care**
- **Occupational Medicine**
- **Physical Therapy**

Care Medical Group's procedures and policies are designed to see walk-in patients in the order of arrival; however, emergencies always take top priority to prevent loss of life and to stabilize the patient. This may lead to longer wait times. Care Medical Group values all of our patients and strives to treat all fairly. This may mean that the wait time for one patient may be longer than another.

We cannot provide accurate wait times since we are unable to predict what each patient may require once they have been brought back to an examination room. The time required to assess and treat each patient varies.

Wait times will differ depending on:

- **Severity and urgency of the condition such as:**
  - **fractures**
  - **lacerations**
  - **seizures**
  - **stroke**
  - **heart attack**
  - **pneumonia**

If estimated wait times are greater than an hour, Care Medical Group offers a courtesy call system. Our Front Desk team will ask you to provide your cell phone number and will call or text you when you are next in queue. Please note that if you return to the clinic within 15 minutes of us sending the phone message, you will be next in line to be seen.

______________________________   _______________
Printed Name   Date of Birth

X_____________________________   _______________
Patient Signature   Date

Care Medical Group
Self-Pay Policy

Thank you for choosing Care Medical Group! We are committed to the success of your medical treatment and care. Prompt payment of your bill is one aspect of your responsibility as it pertains to your treatment and care. We believe that a good provider/patient relationship is based on understanding and open communication. Our staff is instructed to make every effort to clarify any questions concerning payment for your treatment. If you need further information about any of these policies, or about the amount you will be asked to pay today, please ask to speak with our billing department.

You will be considered a self-pay patient if any of the following applies:
- No health insurance;
- Coverage we are unable to confirm at the time of service;
- Insurance plans with which we are not in-network.

The amount you pay today for your office visit depends on several factors including: 1) whether you are a new patient or you've visited our office within the last three years; 2) the complexity of your complaint; 3) the number of issues discussed; and 4) the doctor's examination. The amount our office charges for self-pay office visits is determined based on standard medical coding and billing practices.

The doctor may recommend that other services be performed during your visit in order to effectively evaluate and treat your medical concern. **The costs of these services are separate from your office visit and will incur an additional charge:**
- Lab work
- X-rays
- Diagnostics
- Procedures
- Injections
- Immunizations

Some services are performed or supplied by an external company; in those instances, you may receive a separate bill directly from the outside facility or supplier. For critical results on lab work, additional lab work may be automatically ordered due to concerns of morbidity and mortality.

You have the right to refuse to have a procedure performed or, if you are concerned about the cost of additional services, we can give you a price estimate prior to a service being provided. If you would like an estimate, please notify both the front desk and the provider assisting you today before the services are performed.

We strive to determine the total cost of your services before the conclusion of your visit. In the event that a provided service is not charged at the time of your visit, we will mail you a statement for the balance owing. **Refunds cannot be given same day. Once reviewed and if credit is due, Care Medical Group will refund the credit card used at time of service. If cash payment was made, the refund will be made in the form of a check and mailed to address listed on the account. Charges will not be considered final until they have been processed by the billing department.**

Signature: ______________________________ **Date:** ________________

Printed Name: ______________________________

Authorization for Care Medical Group to Receive, Use or Disclose My Health Care Information

Patient name: ______________________ Date of birth: ____________

Previous name: ______________________

I. My Authorization to: Care Medical Group, PeaceHealth St. Joseph Medical Center, and/or other Provider (s):

You may receive, use or disclose the following health care information (check all that apply):

☒ All health care information in my medical record
☐ Health care information in my medical record relating to the following treatment or condition: ______________________
☐ Health care information in my medical record for the date(s): ______________________
☐ Other (e.g., X rays, bills), specify date(s): ______________________

You may receive, use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use

You may disclose this health care information to:

☒ Name (or title) and organization: Care Medical Group, Inc.
Address: 4280 Meridian St Ste 120 City: Bellingham State: WA Zip: 98226

Reason(s) for this authorization (check all that apply):

☒ at my request
☐ other (specify): ______________________

This authorization ends:

☒ on (date): December 31, 2019
☐ in 90 days from the date signed
☐ when the following event occurs: ______________________

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Care Medical Group, based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from care Medical Group. Or
- Write a letter Care Medical Group.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

______________________ Patient or legally authorized individual signature

______________________ Date

______________________ Printed name if signed on behalf of the patient

______________________ Relationship (parent, legal guardian, personal representative)

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