

NORTHWEST SPINE & SPORTS PHYSICIANS, P.C.

Andrew J. Cole, M.D. ♦ Nelson A. Hager, M.D., M.S. ♦ Garrett S. Hyman, M.D., M.P.H. ♦ Yung J. Lee, D.O.
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PATIENT INFORMATION SHEET

PATIENT'S NAME: _____ Male Female
FIRST INITIAL LAST

Mailing Address: _____

City: _____ State: _____ Zip: _____

PHONE-Home: _____ Business: _____ Cell: _____

Birth date: _____ Social Security #: _____

Employer: _____ Occupation: _____

SPOUSE'S OR PARENT'S NAME: _____ Contact Number: _____

PERSON RESPONSIBLE FOR BILL (If under 18 years):

Name: _____ Phone: _____

Relationship: _____ Address: _____

EMERGENCY CONTACT: Name: _____ Phone: _____

Relationship: _____

REFERRING PHYSICIAN : _____ Phone: _____ City: _____

PRIMARY PHYSICIAN: _____ Phone: _____

► **WAS THIS AN L&I OR MVA ACCIDENT?** Yes No If **YES**, provide following:

L&I INJURY	MOTOR VEHICLE ACCIDENT (We do not bill third party auto claims.)
Claim Number: _____	Claim Number: _____
Date of Injury: [month/day/year] _____	Date of Accident: [month/day/year] _____
Ins. Carrier Name: _____	Your PIP Ins. Co.: _____
Claim Manager's Name: _____	Claim Adjustor's Name: _____
Claim Manager's Phone #: _____	Claim Adjustor's Phone #: _____

► **HEALTH PLAN INFORMATION:** FILL IN COMPLETELY USING YOUR INSURANCE CARD.

PRIMARY INSURANCE:	SECONDARY INSURANCE:
Subscriber Name: _____	Subscriber Name: _____
Subscriber DOB: _____	Subscriber DOB: _____
I.D. # _____	I.D. # _____
Does your insurance require a referral? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, you must bring a copy with you to your appointment.)	Does your insurance require a referral? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES, you must bring a copy with you to your appointment.)

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING

Assignment, Release and Financial Agreement: I authorize treatment of 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 to referring/consulting physicians or other health care providers as your physician deems appropriate to facilitate my/our care. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have also been informed of the \$35.00 fee on checks returned per RCW 62A.3 515 & 520. 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 fees and any other costs.

Patient's Signature/Parent's Signature

Date

YEARLY UPDATE

▪ I certify that I have reviewed the information on this form in its entirety, and there are **no changes**.

Patient's Signature/Parent's Signature

Date

▪ I certify that I have reviewed the information on this form in its entirety, and there are **no changes**.

Patient's Signature/Parent's Signature

Date

PHOTO ID: (For office use)