REGISTRATION FORM

OVERLAKE MEDICAL CLINICS

DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE	PREFERRED NAME
ADDRESS		CITY STATE ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL ADDRESS		MARITAL STATUS	
BIRTH DATE	SEX	SSN	SPOUSE/ PARTNER'S NAME
EMPLOYER NAME	EMPLOYER ADDRESS		
EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	RELATIONSHIP	RIGHTS TO YOUR INFO ☐YES ☐NO

PRIMARY LANGUAGE: ☐ENGLISH ☐INDIAN (incl. Hindi & Tamil) ☐ RUSSIAN ☐SPANISH ☐OTHER:

ETHNICITY ☐HISPANIC ☐NON-HISPANIC ☐PREFER NOT TO DISCLOSE

RACE

☐AMERICAN INDIAN OR ALASKAN NATIVE
☐ASIAN
☐NATIVE HAWAIIAN
☐BLACK OR AFRICAN AMERICAN
☐WHITE
☐HISPANIC OR LATINO
☐OTHER RACE
☐OTHER PACIFIC ISLANDER
☐PREFER NOT TO DISCLOSE

PRIMARY CARE PROVIDER: . PCP PHONE:

REFERING PROVIDER (if you were referred to us by another doctor)

HOW DID YOU HEAR ABOUT US? (PLEASE CHECK ONE)

☐ESTABLISHED PATIENT
☐PERSONAL REFERRAL (FRIEND, FAMILY, ANOTHER PATIENT)
☐ADVERTISEMENT
☐OVERLAKE WEBSITE / ONLINE
☐OVERLAKE PHYSICIAN REFERRAL LINE
☐INSURANCE COMPANY PROVIDER LIST OR WEBSITE
☐EMPLOYER
☐SAW THE SIGN
☐PROVIDER (PLEASE NAME BELOW)

INSURANCE

Who is to be billed for today's visit?

☐INSURANCE ☐SELF ☐LABOR & INDUSTRIES* ☐MOTOR VEHICLE INSURANCE* ☐3RD PARTY INSURANCE*

***PLEASE FILL IN THE INFORMATION IN THE "MOTOR VEHICLE INSURANCE / LABOR & INDUSTRIES / THIRD PARTY" SECTION ON THE NEXT PAGE**

PRIMARY

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO INSURED
INSURANCE BILLING ADDRESS (Usually located on back of card)		GROUP EMPLOYER NAME
INSURANCE PHONE NUMBER		

SECONDARY

INSURANCE COMPANY NAME	POLICY NUMBER	GROUP NUMBER
SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH	RELATIONSHIP TO INSURED
INSURANCE BILLING ADDRESS (Usually located on back of card)		GROUP EMPLOYER NAME
INSURANCE PHONE NUMBER		

L&I or MVA

DATE OF INJURY/ACCIDENT	JOB RELATED? ☐YES ☐NO	ACCIDENT ☐AUTO ☐NON-AUTO ☐N/A	CAUSE OF ACCIDENT
CLAIM NUMBER	CLAIM ADJUSTER NAME		CLAIM ADJUSTER PHONE
CLAIMS MAILING ADDRESS			

Name , DOB

AUTHORIZATION FORM

AUTHORIZATION

It is our responsibility to protect your medical records and we do not provide any information regarding you or your medical conditions without your written consent. Please list below any other healthcare providers or anyone else with whom we may discuss your medical conditions.

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

PHONE CALLS/MESSAGES

We often call patients for the reasons listed below. Please mark which number we may call to leave messages.

Is it OK to leave a message to confirm your appointment?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

Is it OK to leave a message with results of lab or imaging studies?

☐ Home ☐ Cell ☐ No, do not call to leave a message at the home or cell number

Is it OK to MAIL the results of lab or imaging studies to your home address?

☐ Yes ☐ No

PHARMACY

MAIL ORDER PHARMACY? MAIL ORDER PHARMACY NAME

☐ YES ☐ NO

PREFERRED PHARMACY? PREFERRED PHARMACY NAME PREFERRED PHARMACY PHONE

☐ YES ☐ NO

PAYMENT / CONSENT TO TREAT

I authorize Overlake Medical Clinics, LLC to release any and all information required to process an insurance claim for payment as allowed by law.

I authorize the medical and other staff of Overlake Medical Clinics, LLC permission to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my health problems. I understand that medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. This authorization shall remain in effect unless the consent is cancelled by written notice to the Medical Director.

I authorize payment of medical benefits to be paid directly to Overlake Medical Clinics, LLC for services received. I understand that I am financially responsible for any balance due.

My signature acknowledges understanding and consent to this information.

_____ _____

Signature Date

PERMISSION TO CONTACT FOR RESEARCH

Overlake Medical Clinics and our research partners participate in clinical trials that are designed to lead to better treatments for the types of medical problems experienced by the people who come to this clinic. If you are a potential candidate for a research trial, may we contact you to discuss possible participation? ☐ YES ☐ NO

OVERLAKE MEDICAL CLINICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record.

By my signature below I, **,** acknowledge that I received a copy of the Notice of Privacy Practices for Overlake Medical Clinics, LLC.

_____ _____

Signature of patient (or personal representative) Date

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

Personal Representative's Name: _____

Relationship to Patient: _____

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 (Please Specify)

_____

_____

_____ _____

Employee Name Date

Updated 9/26/12