NORTHWEST HEALTH SERVICES, INC.

PATIENT INFORMATION:

Name: _____ **Social Security Number:** _____
First Middle Initial Last

Date of Birth: _____ **Gender:** _____
Mo/Day/Year M/F

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Home Phone:** _____

Street Address (if different than mailing address): _____

City: _____ **State:** _____ **Zip Code:** _____

SPOUSE/GUARDIAN INFORMATION:

Relationship to Patient: _____
(It is the policy of Northwest Health Services that the parent that requests treatment for the minor child is responsible for all fees)

Name: _____ **Social Security Number:** _____
First Middle Initial Last

Date of Birth: _____ **Gender:** _____
Mo/Day/Year M/F

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Home Phone:** _____

Street Address (if different than mailing address): _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Employment Status:** _____
Full time/Part time/None

Employer's Address: _____ **Employer's Phone:** _____
City State Zip

Name: _____ **Date of Birth:** _____
First Middle Initial Last Mo/Day/Year

EMERGENCY CONTACT INFORMATION:

Primary Contact Name: _____ **Relationship:** _____

Address: _____
Street City State Zip Code

Home Phone: _____ **Work phone:** _____

Secondary Contact Name: _____ **Relationship:** _____

Address: _____
Street City State Zip Code

Home Phone: _____ **Work phone:** _____

Name: _____ **Date of Birth:** _____
First Middle Initial Last Mo/Day/Year

INSURANCE INFORMATION:

Medicare Number: _____ **Medicaid Number:** _____

Primary Insurance Plan: _____ **Policy Number:** _____

Group #: _____ **Group Name:** _____ **Effective Date:** _____

Co-pay Amount: _____ **Primary Care Physician (PCP):** _____

Name of Insured (If different than self): _____ **Relationship to Patient:** _____

Gender: _____ **Insured's Date of Birth:** _____ **Insured's Phone Number:** _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer: _____ **Employment Status:** _____
Full time/Part time

Insured's Employer's Address: _____
City State Zip

Secondary Insurance Plan: _____ **Policy Number:** _____

Group #: _____ **Group Name:** _____ **Effective Date:** _____

Co-pay Amount: _____ **Primary Care Physician (PCP):** _____

Name of Insured (If different than self): _____ **Relationship to Patient:** _____

Gender: _____ **Insured's Date of Birth:** _____ **Insured's Phone Number:** _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer: _____ **Employment Status:** _____
Full time/Part time

Insured's Employer's Address: _____
City State Zip

Name: _____ **Date of Birth:** _____
First **Middle Initial** **Last** **Mo/Day/Year**

Northwest Health Services is a Federally Qualified Health Center (FQHC). As such, we are required to complete reports on the following information.

1. Marital Status:
- ____**Single**
- ____**Married**
- ____**Divorced**
- ____**Widowed**
- ____**Separated**
- ____**Life Partner**
- ____**Legally Separated**
- ____**Unknown**

2. Student Status:
- ____**Full Time**
- ____**Part Time**
- ____**Not In School**

3. Patient Employment Status:
- ____**Full Time**
- ____**Part Time**
- ____**None**

4. Guarantor Employment Status:
- ____**Full Time**
- ____**Part Time**
- ____**None**

5. Referral Physician: _____

6. Preferred Pharmacy: _____
City/Location:_____

7. Language Most Spoken:
- ____ **Chinese**
- ____ **English**
- ____ **French**
- ____ **German**
- ____ **Italian**
- ____ **Japanese**
- ____ **Other**
- ____ **Spanish**
- ____ **Sign Language**

8. Housing Status:
- ____ **Not Homeless (home/trailer/apt etc.)**
- ____ **Doubling Up (2/more families living together)**
- ____ **Homeless Shelter**
- ____ **Street (homeless)**
- ____ **Transitional (temporary residence)**

9. Employment:
- ____ **Employed / Self Employed / Unemployed / Retired**
- ____ **Migrant Agricultural Worker / Dependent**
- ____ **Seasonal Agricultural Worker / Dependent**

9. Veteran Status:
- ____ **Yes**
- ____ **No**

10. Employer:_____

11. Race:
- ____ **American Indian or Alaska Native**
- ____ **Asian**
- ____ **Black or African American**
- ____ **Hispanic**
- ____ **Native Hawaiian**
- ____**Other Pacific Islander**
- ____**Refused / Unreported**
- ____**White**

12. Income Verification Code (Office Use Only): _____

Name: _____ **Date of Birth:** _____
First **Middle Initial** **Last** **Mo/Day/Year**

ALL PATIENTS:
I, the undersigned, do consent for treatment as deemed necessary by the attending health care provider.

SIGNATURE: _____ **DATE:** _____

ALL CHARGES ARE DUE AT THE TIME THAT SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE VISIT

I authorize ***NORTHWEST HEALTH SERVICES, INC.*** to release any medical information necessary to process claims and further authorize payment of medical benefits payable directly to ***NORTHWEST HEALTH SERVICES, INC.*** I understand that ***NORTHWEST HEALTH SERVICES, INC.*** will file and complete the necessary steps to collect my insurance payment. However, if my insurance doesn't respond or payment is not made within 90 days, I understand that it is my responsibility to pay for any services rendered by ***NORTHWEST HEALTH SERVICES, INC.*** I further understand that ***NORTHWEST HEALTH SERVICES, INC.*** may not be contracted with my insurance plan and I agree that I am responsible for charges denied for such reasons.

SIGNATURE: _____ **DATE:** _____

CONSENT FOR TREATMENT FOR MINOR: By signing this consent I represent that I have the legal responsibility for and authority to direct the medical treatment of the above patient, either as parent or legal guardian and I will hold harmless any attending physician or other person or entity against any claim that medical treatment provided to the above patient was not authorized. This consent includes this and subsequent office visits for which I bring this minor to this office. My permission also extends to releasing this medical record to consulting physicians if ever required to adequately diagnose and treat this minor.

SIGNATURE: _____ **DATE:** _____

MEDICARE PATIENTS ONLY: LIFETIME CONSENT FORM: I request that payment of Medicare Benefits be made payable to ***NORTHWEST HEALTH SERVICES, INC.*** on my behalf. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits.

SIGNATURE: _____ **DATE:** _____

(*Please answer the following questions. These are commonly asked questions from your insurance company and with the following questions answered it will help with getting your claim processed more quickly and accurately)*

1. Is this visit related to an accident? _____ YES _____ NO

If yes, please complete the following: IF A MEDICARE PATIENT ANSWERS YES, PLEASE COMPLETE A MSP FORM FOR MEDICARE.

a) Date of Accident: _____
b) Where accident occurred: (home, school, or other) _____
c) How: (explain in detail how the accident happened) _____
_____
d) Was this injury or accident work related: _____YES _____NO

(If you answered yes to this question, please complete the information sheet for Worker's Compensation.)