Fill out this form to register as a Northwest Health Services' patient.

NORTHWEST HEALTH SERVICES

Today's Date:	**Northwest Health Care Provider:**

Patient Information (Please Print)

☐ Mr. ☐ Miss ☐ Mrs.	☐ Dr. ☐ Ms.	Last Name:	First Name:	Middle:	Suffix: ☐ Jr. ☐ Sr. ☐ Other

Former Name:	Nickname:	SS#:	Birthdate: / /	Sex Assigned at Birth: ☐ M ☐ F

Home Street Address:	City:	State:	Zip Code:	Country:	County:
Billing Street Address (if different):	City:	State:	Zip Code:	Country:	County:

Home Phone:	Work Phone:	Cell Phone:

Email Address:

May we email or text appointment reminders and short surveys? ☐ Email ☐ Text Message

Race (mark below):	Preferred Language (mark below):	Ethnicity (mark below):
☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other ☐ More than One Race ☐ Refused to Report	☐ English ☐ Spanish ☐ French ☐ German ☐ Japanese ☐ Italian ☐ Sudanese ☐ Burmese ☐ Tigrinya ☐ Declined to Answer ☐ Other	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown ☐ Declined to Report

Contact Preference:	Marital Status:	Student Status:	Veteran:
☐ Home Phone ☐ Cell Phone ☐ Confidential ☐ Don't Call Home ☐ Don't Call Work ☐ Don't Leave Message ☐ Okay to Leave Message	☐ Single ☐ Married ☐ Life Partner ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Declined to Specify	☐ Full Time ☐ Part Time ☐ Not a Student	☐ Yes ☐ No

PERSON RESPONSIBLE FOR BILL

Last Name:	First Name:	Middle Name:	Previous Last Name:	Nickname:

SS#:	Birthdate: / /	Relationship: ☐ Self ☐ Parent ☐ Life Partner ☐ Spouse ☐ Other

Street Address:	City:	State:	Zip Code:	Country:	County:

Home Phone:	Work Phone:	Cell Phone:

NORTHWEST HEALTH SERVICES

INSURANCE INFORMATION

Primary Insurance: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ United Healthcare ☐ Other _____

Name of Insured:	Plan Number:	Policy Number:		Group Name:	Group Number:
Insurance Company Street Address:	City:	State:	Zip Code:	County:	
Effective Date: / /		Expiration Date: / /			
Patient Signature:				Today's Date:	

Secondary Insurance: ☐ Medicare ☐ Medicaid ☐ BCBS ☐ United Healthcare ☐ Other _____

Name of Insured:	Plan Number:	Policy Number:		Group Name:	Group Number:
Insurance Company Street Address:	City:	State:	Zip Code:	County:	
Effective Date: / /		Expiration Date: / /			

How Did You Hear About Us (Please Select All that Apply):
☐ Billboard ☐ Community Event ☐ Friend/Family ☐ Newspaper ☐ Radio
☐ Social Media ☐ TV Commercial ☐ On Premise Signage

EMPLOYER INFORMATION

Employer Name:					
Employer Street Address:	City:	State:	Zip Code:	Country:	County:

Occupation:	Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Active Duty ☐ Retired ☐ Self Employed ☐ Unknown	Work Phone:	Retirement Date: / /

EMERGENCY CONTACT / NEXT OF KIN

Last Name:	First Name:	Relationship:	Phone Number:
Street Address:	City:	State:	Zip Code:

HOUSING & WORKER STATUS

Homeless Status: ☐ Doubling Up ☐ Not Homeless ☐ Shelter ☐ Street ☐ Transitional	Migrant Worker Status: ☐ Migrant Worker ☐ Not a Farm Worker ☐ Seasonal Worker

INCOME TABLE				
Family Size	Income	Income	Income	Income
1	☐ $0-$11,880	☐ $11,881-$17,820	☐ $17,821-$23,760	☐ Over $23,761
2	☐ $0-$16,020	☐ $16,021-$24,030	☐ $24,031-$32,040	☐ Over $32,041
3	☐ $0-$20,160	☐ $20,261-$30,240	☐ $30,241-$40,320	☐ Over $40,321
4	☐ $0-$24,300	☐ $24,301-$36,450	☐ $36,451-$48,600	☐ Over $48,601
5	☐ $0-$28,440	☐ $28,441-$42,660	☐ $42,661-$56,880	☐ Over $56,881
6	☐ $0-$32,580	☐ $32,581-$48,870	☐ $48,871-$65,160	☐ Over $65,161
7	☐ $0-$36,730	☐ $36,731-$55,095	☐ $55,096-$73,460	☐ Over $73,461
8	☐ $0-$40,890	☐ $40,891-$61,335	☐ $61,336-$81,780	☐ Over $81,781

READ AND SIGN THIS SECTION

1. I, the patient:
    - Allow my health care provider to give me the treatment I need. This care may include but is not limited to:
        - Radiology to diagnose a problem, tests which may look for contagious diseases such as Hepatitis and HIV/AIDS, taking samples of body fluids or body tissue, ad giving medicine, immunizations and vaccines.
    - Allow my provider to treat me in emergencies if it may save my life or health.
    - Agree that my care at NHS emphasizes care coordination and communication into what we, as a team, deem best for me.
    - Allow Northwest Health Services, Inc. (NHS) to release any of my health information to process my claims.
    - Allow payment for my treatment to be given to NHS.
    - Agree that NHS will file and complete the steps to collect my insurance payment.
    - Agree that if my insurance doesn't pay for my care, I am in charge of paying for my treatment.
    - Agree that NHS must have a contract with my insurance. If there is no contract, I am in charge of paying for my treatment.

All fees are due when you get your treatment, unless you make other plans before your visit.

Sign: _____ Date: _____

IF YOU ARE A PARENT OR LEGAL GUARDIAN OF A MINOR, READ AND SIGN THIS SECTION

CONSENT FOR TREATMENT OF A MINOR

2. I agree that:
    - I have the legal responsibility for this patient.
    - I have the legal right to direct the medical treatment of this patient.
    - By signing the consent includes this and later office visits.
    - This health record may be given to other providers to treat this minor as needed.

Sign:_____ Date:_____

IF YOU ARE A MEDICARE PATIENT, READ AND SIGN THIS SECTION

LIFETIME CONSENT FORM

3. I request payment of Medicare Benefits be made to NHS on my behalf. I allow anyone who has my health record to release it to Heath Care Financing Administration and its agents:

   Sign:_____ Date:_____

READ AND SIGN THIS SECTION REGARDING WORKER COMPENSATION

4. I agree to report any accident or work related injuries to ensure processing of my insurance or Worker's Compensation to the appropriate responsible company.

   Sign:_____ Date:_____

   Please ask a Patient Access Assistant at the front desk for Worker's Compensation forms when needed.

PATIENT PORTAL CONSENT

The patient Portal allows for electronic access to view personal medical history, update personal information, and ensure patient information is correct and complete. **The portal is NOT to be used to communicate Urgent or Emergency issues.** Patients must be 18 years of age to access the portal.

Name:

Signature:

Cell Phone Number: