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:	Preferred Language:	Ethnicity:	Gender Identity:
☐ 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	☐ Female ☐ Male ☐ Female-to-Male (FTM) *Transgender Male* ☐ Male-to-Female (MTF) *Transgender Female* ☐ Other ☐ Choose Not to Disclose

Sexual Orientation:	Contact Preference:	Marital Status:	Student Status:	Veteran:
☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Don't Know ☐ Something Else ☐ Choose Not to Disclose	☐ 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:

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:

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

INCOME TABLE				
Family Size	Income	Income	Income	Income
1	☐ $0-$12,140	☐ $12,141-$18,210	☐ $18,211-$24,280	☐ Over $24,281
2	☐ $0-$16,460	☐ $16,461-$24,690	☐ $24,691-$32,920	☐ Over $32,921
3	☐ $0-$20,780	☐ $20,781-$31,170	☐ $31,171-41,560	☐ Over $41,561
4	☐ $0-$25,100	☐ $25,101-37,650	☐ $37,651-$50,200	☐ Over $50,201
5	☐ $0-$29,420	☐ $29,421-$44,130	☐ $44,131-$58,840	☐ Over $58,841
6	☐ $0-$33,740	☐ $33,741-$50,610	☐ $50,611-$67,480	☐ Over $67,481
7	☐ $0-$38,060	☐ $38,061-$57,090	☐ $57,091-76,120	☐ Over $76,121
8	☐ $0-$42,380	☐ $42,381-63,570	☐ $63,571-84,760	☐ Over $84,761

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.

NORTHWEST HEALTH SERVICES

WHO CAN HAVE YOUR HEALTH INFORMATION?

Please fill out this form. It will tell us which family members and friends have your permission to have your health information.

Patient Name:	Date of Birth:

ABOUT THIS FORM:

- Lets those listed below have information about your medical care or payment
- Informs those listed blow or a disaster relief organization of your location, health or death.

THESE PEOPLE CAN HAVE MY HEALTH INFORMATION:

1. Name:		Relationship to you:	
Phone Number:	Street Address:		
City:		State:	Zip Code:
2. Name:		Relationship to you:	
Phone Number:	Street Address:		
City:		State:	Zip Code:
3. Name:		Relationship to you:	
Phone Number:	Street Address:		
City:		State:	Zip Code:

PLEASE SIGN HERE:

By signing below, I allow Northwest Health Services to talk about or release my health information with the people listed above. **Mark all that you approve:**

☐ My Health ☐ Lab Tests ☐ HIV Records ☐ My Treatment

☐ Other_____

☐ Behavioral Health Records ☐ Mental Health Assessment ☐ Progress Notes

Patient/Guardian Signature:	Today's Date

Your permission expires in one year unless cancelled in writing.

By signing below, I acknowledge that I have received a Notice of Privacy Practices from Northwest Health Services.

Patient Signature:	Date:
Print Name:	
Signature of parent or patient's representative (if it applies):	
Please describe your legal right to act on behalf of the patient:	

COMPLAINTS:

If you believe your privacy rights have been violated , you may file a complaint with us. All complaints must be given in writing on the form provided by NHS. To obtain a form, contact NHS or call the Director Quality Improvement at (816) 271-8227. You also may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. **You will not be penalized for filing a complaint.**