PATIENT REGISTRATION & INSURANCE ASSIGNMENT

The Charis Clinic PLLC, 23601 Hwy 99 Ste A, Edmonds WA 98026

Last Name _____ First Name _____ Middle Initial ____ Sex _____
Address _____

City _____ State _____ WA _____

Email Address _____ Birthdate _____

Home Phone (required) _____ Cell Phone (required) _____

Relationship Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered for _____ yrs ☐ Minor

Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone _____
Referred by _____Emergency Notification Name & Relationship_____ Emergency phone # _____

PRIMARY INSURANCE

Person Responsible for Account (Last name) _____ (First Name) _____(MI)_____

Relation to Patient _____Birthdate _____ Social Security # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Insurance Company _____

Contract # _____Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

SECONDARY/ADDITIONAL INSURANCE (complete if indicated)

Person Responsible for Account (Last name) _____ (First Name) _____(MI)_____

Relation to Patient _____Birthdate _____ Social Security # _____

Address (if different from patient) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Insurance Company _____

Contract # _____Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to The Charis Clinic PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The Charis Clinic PLLC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient