



PATIENT REGISTRATION & INSURANCE ASSIGNMENT

The Charis Clinic PLLC, 7631 212th St SW Ste 101A, Edmonds WA 98026

Last Name _____ First Name _____ Middle Initial ____ Sex _____

Address _____

City _____ State _____ Zip _____

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 _____

Subscriber # _____ Group # _____ Name of Plan: _____

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