Rehabilitation Institute of Washington, PLLC

Date _____ **REGISTRATION FORM** Clinic No. _____

PATIENT INFORMATION

Name _____ SSN _____

Home Address _____ City: _____ State: _____ Zip: _____

Mailing Address (if different)_____ City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Separated ☐ Divorced ☐ Partnered

Patient Employer/School _____ Occupation _____

Referring Physician or Source _____

In case of emergency who should be notified? _____ Phone _____

RESPONSIBLE PARTY OR PARENT INFORMATION

Name _____ Relationship to Patient _____

Address (if different from above)_____ City: _____ State: _____ Zip: _____

Home Phone _____ Cell Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Insurance Phone _____

Insured's Name _____ Relationship to Patient _____ Birthdate _____

ID Number _____ Group _____

Secondary Insurance _____ Insurance Phone _____

Insured's Name _____ Relationship to Patient _____ Birthdate _____

ID Number _____ Group _____

PLEASE COMPLETE THIS SECTION IF YOUR CONDITION IS ACCIDENT-RELATED

Date of Accident _____ Type of Accident ☐ Auto ☐ Work ☐ Other _____

Insurance Company _____ Adjuster _____ Phone _____

Claim Number _____ Employer (if work-related) _____ Insured _____

Attorney's Name/Address/Phone _____

GENERAL CONSENT / ASSIGNMENT OF BENEFITS

Consent for Health Care Services: I authorize consent for medical treatment provided by the Rehabilitation Institute of Washington (RIW).
Advance Consent to Treat Minors: Being the parent/legal guardian of the above minor, I authorize and consent to routine medical treatment for him/her when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.
Authorization for Release of Information: The Rehabilitation Institute of Washington and my physician may release information from my medical records to any health care provider involved in my care and treatment, as well as any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, and my employer's workers' compensation carrier.
Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by the Rehabilitation Institute of Washington and of my physician, which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 30 days from the date the bill was mailed by RIW, I understand that interest charges of 1.0% per month may be added to my bill.
Preauthorization Requirements: I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of RIW charges.
Assignment of Benefits: I authorize that payment of any insurance benefits for healthcare services or goods may be made directly to the Rehabilitation Institute of Washington and my physician.

_____ _____

Signature of Patient or Responsible Party Date