

PUGET SOUND ORTHOPAEDICS, P.S.

A Division Of Proliance Surgeons Inc. P.S.

7308 BRIDGEPORT WAY - STE 201, LAKEWOOD, WA 98499 • (253) 582-7257

DATE: _____

PATIENT INFORMATION:

FULL NAME: _____
LAST FIRST MI

ADDRESS: _____
CITY STATE ZIP

AGE: ___ BIRTHDATE: ___/___/___ SEX: ___ M ___ F S.S.#: _____ - _____ - _____ MARITAL STATUS: SINGLE MARRIED OTHER

HOME PHONE #: (_____) _____ CELL/MESSAGE PHONE #: (_____) _____

EMAIL ADDRESS: _____

HOW WERE YOU REFERRED TO US?: _____ PRIMARY CARE DR.: _____

EMPLOYER: _____ WORK PHONE #: (_____) _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ THEIR PHONE NO.: _____

RESPONSIBLE PARTY INFORMATION (MINORS UNDER 18):

SEX: MALE FEMALE

FULL NAME: _____
LAST FIRST MI BIRTHDATE: _____/_____/_____

ADDRESS: _____
CITY STATE ZIP SOCIAL SECURITY: _____ - _____ - _____
HOME PHONE #: (_____) _____

PT. RELATION TO RESPONSIBLE PARTY: _____ EMPLOYER PH #: (_____) _____

EMPLOYER: _____ TYPE OF WORK YOU DO: _____

MEDICAL PROBLEM OR INJURY INFORMATION:

WHAT IS THE CAUSE OF YOUR INJURY OR NATURE OF MEDICAL PROBLEM? _____

IF INJURED, WHERE DID IT HAPPEN? _____ DATE OF INJURY: _____

BODY PART INJURED: _____ LEFT _____ RIGHT _____

IS YOUR INJURY WORK RELATED? YES ___ NO ___ IF SO, CLAIM # _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ PT. RELATION TO INSURED: _____

ADDRESS: _____
CITY STATE ZIP POLICY #: _____

INSURED'S NAME: _____ GROUP #: _____

INSURED'S BIRTHDATE: _____/_____/_____ SOCIAL SECURITY: _____ - _____ - _____

INSURED'S EMPLOYER: _____ BUSINESS PHONE #: (_____) _____

SECONDARY INSURANCE: _____ PT. RELATION TO INSURED: _____

ADDRESS: _____
CITY STATE ZIP POLICY #: _____

INSURED'S NAME: _____ GROUP #: _____

INSURED'S BIRTHDATE: _____/_____/_____ SOCIAL SECURITY: _____ - _____ - _____

INSURED'S EMPLOYER: _____ BUSINESS PHONE #: (_____) _____

CONSENT FOR TREATMENT - RELEASE OF INFORMATION - ASSIGNMENT OF INSURANCE BENEFITS

I authorize examination and treatment for myself or family. I understand that I am responsible for any bills incurred by myself or family for medical treatment regardless of insurance coverage or third party liability. I hereby authorize assignment of insurance benefits to be paid directly to my Lakewood Orthopaedic Surgeon physician and/or physical therapist. I authorize release of information to the insurance companies listed above. I authorize release of information to my coach, athletic trainer and school/organization to facilitate my safe participation in organized sports activity.

SIGNATURE

DATE

RELATIONSHIP TO PATIENT (IF UNDER 18)



**Puget Sound
Orthopaedics**
a division of proliance surgeons

Julian Arroyo, MD
Brandt Bede, MD
John Blair, MD
Spencer Coray, MD
Dale Hirz, MD
Sean Laghaeian, DPM
Michael Martin, MD
Steven Teeny, MD
Alan Thomas, MD, PhD

Acknowledgement of Receipt Offer of Notice of Privacy Practices

Dear Patient,

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice.

You have the right to review our notice before signing this acknowledgment, and, if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request.

We appreciate you signing this form, which acknowledges that your have received, or have been offered and refused, a copy of our Notice.

Patient Name _____

Patient/Representative Signature _____

Date _____

7308 Bridgeport Way W, Suite 201
Lakewood WA 98499-8000
253-582-1617 Fax
253-582-7257 Phone
pugetsoundorthopaedics.com

1515 Martin Luther King Jr. Way
Tacoma WA 98405-3933
253-272-2642 Fax
253-572-2663 Phone



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Our Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of our treatment. The following is a statement of our financial policy which we require you read and sign prior to your treatment:

OUR RESPONSIBILITY

- To bill all claims to your insurance carrier(s) in a timely manner.
- To assist you in resolving any problems with claim payment.

YOUR RESPONSIBILITY

- To provide us with accurate information to submit your claims correctly.
- To make certain there is an authorization for our physicians to treat you if it is required by your insurance.
- To pay your co-payment at the time of service.
- To pay any additional amount owed as directed by your insurance carrier within 30 days of receipt of your first statement from us.

If you are having difficulty making payments, we will make every effort to help you find a solution. However, if any balance remains on your account after 60 days, and payment arrangements have not been made with our patient accounts department, your account will be turned over to our collection agency, Audit and Adjustment Company. Office policy states that once an account is in collection status you will be discharged from our practice.

Signature _____ Date _____

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