PALOUSE MEDICAL P.S.
YOUR HEALTH PARTNER

# Patient Profile

*Today's Date:*_____

*Appointment With:* _____

## PATIENT INFORMATION

*(Please Print All Information—Thank you!)*

**Name:** _____

**Middle Initial** _____ **Date Of Birth:** _____

**Marital Status:** ☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Other ☐ Widowed

**Mailing Address:** _____

_____

**City/State:**_____ **Zip Code:**_____

**Contact Phone Numbers:**

*Primary* (_____) _____ ☐ Home ☐ Work ☐Cell

*Secondary* (_____) _____ ☐ Home ☐ Work ☐Cell

**E-mail** _____
*(If over 18 yrs. of age)*

**Sex:** ☐ Male ☐ Female ☐ Other

**Social Security #:** _____

**Primary Physician:** _____

**Referring Physician:** _____

**Language Spoken:** _____

**Race:** _____

**Ethnicity**_____

**Employment Status:** ☐Retired ☐ Unemployed ☐ Student

**Employer/School:** _____

**Name of Assisted Living Facility If Applicable**

_____

**EMERGENCY CONTACT**

Name: _____

Relationship: _____

Phone Number: _____

## LEGALLY RESPONSIBLE (GUARANTOR) INFORMATION

☐ Same as Patient

Name: _____

Address: _____

_____

City/ST _____ Zip Code:_____

Employer: _____

Phone: (____) _____

Phone: (____) _____

Social Security #: _____

Date of Birth: _____

**** ONLY Fill Out The Following Section If Your Insurance Card Is Not Present During Registration****

## PRIMARY INSURANCE

☐ Same as Patient ☐ Same as Guarantor ☐ Other

Insured Party: _____

Insured Phone: _____

Social Security #: _____

Date of Birth: _____

Relationship to Primary: _____
Insured/Guarantor

Company: _____

Insured ID: _____

Policy Group: _____

*If you also have secondary insurance, please speak with the front office.*

## Financial Agreement & Release of Information

*I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Palouse Medical, P.S. for any services furnished to me by Palouse Medical, P.S. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to determine these benefits or the benefits payable for related services.*

*I authorize the release of my personal Health Care Information that might be required for processing my insurance claims by insurance companies through which I am covered, or any subsequent insurance companies from which I obtain coverage.*

## Office Policy Agreement

*I understand that my services will be billed to my insurance company(s) provided I have given proof of my insurance coverage at the time services are rendered.* ***If I do not have proof of insurance coverage at the time services are rendered, I understand that payment is due at the time of service.*** *I will promptly pay all amounts that have been determined my responsibility by my insurance carrier within 30 days of notification.*

*If I am* ***over*** *the age of 18, I am ultimately responsible for any patient balance for services I have received. If I am* ***under*** *the age of 18, my parent or legal guardian is responsible for my patient balance until my 18th birthday.*

***Patient Signature*** _____ ***Date*** _____

***Signature of Parent / Legal Guardian*** _____

## Notice of Privacy Practices – Acknowledgement

Palouse Medical and Pullman ReadyCare has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Palouse Medical's Privacy Official at 509-332-2517 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

*Our* ***Notice of Privacy Practices*** *describes in more detail how your health information may be used and disclosed, and how you can access your information.*

By initialing below,
**I agree I have received the Notice of Privacy Practices of Palouse Medical and Pullman Readycare**

_____Patient's Initials

***Form Filled Out Entirely*** _____
***Employee Initials***

*This form will be retained in your medical record.* *Last Updated April 8th, 2016*