Puget Sound Rheumatology

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Poulsbo, WA 98370
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Email: PSR@psrheum.com
Web: www.psrheum.com

Patient's Name: Last _____ First _____ M. I. ____ Sex: M / F (circle one)

Date of Birth ____/____/____ Home # _____ Cell # _____ Work # _____

Home address _____ City _____ State ____ Zip_____

Email Address _____ Soc. Sec. _____

Emergency Contact Name _____ Phone _____ Relationship _____

Select PREFERRED CONTACT METHOD for all communication, especially appointment confirmation (check one):

☐ Phone (best number / best time to reach you)_____ /_____ ☐ Email ☐ Post Card

Primary Insurance Information

Insurance & Policyholder Name _____ Date of Birth ____/____/____

Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Secondary Insurance Information

Insurance & Policyholder Name _____ Date of Birth ____/____/____

Relationship to Policyholder: Self _____ Spouse _____ Child _____ Other _____

Work Comp and PIP Insurance Information

Employer Name _____

Address _____ City _____ State ____ Zip _____

Date of Injury ____/____/____ State where injury occurred _____

Injury is: Work related _____ Car Accident _____ Other (describe) _____

Responsible party name if patient is minor: Last _____ First _____ M. I. _____

HIPPA Acknowledgment: I hereby acknowledge that I have been made aware that Puget Sound Rheumatology has a Privacy Policy in place accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a patient I acknowledge the following: Puget Sound Rheumatology has a Privacy Policy in effect and has made this policy available for review. I am entitled to a copy of the Privacy Policy if I desire a copy for my personal file. Upon your review of the above, please sign at the bottom acknowledging that you have been advised of the Privacy Policy implemented by Puget Sound Rheumatology and have read and understand the form. If you desire a copy of the Privacy Policy please request one at this time.

☐ No, I do not wish to obtain a copy of the HIPAA Privacy Policy but I am aware that one exists.

☐ Yes, I do want a copy of the HIPAA Privacy Policy

Policy was given to patient on ____/____/____ (date) by _____, PSR Representative

I authorize the release of any previous results or images in the event PSR is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. PSR will bill my insurance carrier as a courtesy. In the event of non-payment, I understand I will be responsible for any outstanding balances.

☐ I acknowledge that I have received and read a copy of "About PSR," including the PSR cancellation policy.

☐ I give PSR permission to leave a voice message on my preferred phone number voice mail.

Patient signature or guardian for the minor patient _____ Date _____/____/____