# South Sound Surgical Associates

3920 Capital Mall Dr. SW Suite 203. Olympia, Washington 98502
Phone: (360) 754-3507 Fax: (360) 236-1457

**PATIENT INFORMATION (please print)**

Patients Name _____Birth date _____
Last First MI

Male____ Female____

Child____ Single____ Married____ Separated____ Other____

Address _____
Street City State Zip

Telephone: Home _____ Cell_____ Work_____

Social Security Number _____-____-_____Email Address_____

Patient's Employer _____Occupation_____

Spouse's Name_____ Social Security Number _____-____-_____

Spouse's Employer_____ Telephone _____

**IF PATIENT IS A MINOR (Under 18 Years)**

Responsible party _____Relationship_____

Social Security Number _____-____-_____ Birth date_____

Address _____
Street City State Zip

Employer's Name_____

Address _____
Street City State Zip

Telephone: Home _____Work_____

**Emergency Contact (Name of a relative or friend living at another address)**

Name_____Relationship_____

Address _____
Street City State Zip

Telephone: Home _____Work_____

Whom may we thank for referring you? _____

I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent or Guardian Signature _____Date_____

**PLEASE COMPLETE REVERSE SIDE**

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## INSURANCE INFORMATION

Primary Insurance_____

Subscriber Name_____Relationship_____

Subscriber ID Number or Social Security Number_____

Birth date_____ Group Number_____

Secondary Insurance_____

Subscriber Name_____Relationship_____

Subscriber ID Number or Social Security Number_____

Birth date_____ Group Number_____

Medicare (We accept assignment on all Medicare claims)

Medicare number_____

Name of Supplemental Insurance_____

Subscriber Name _____SSN_____-_____-_____Group number_____

Is insurance provided through current or former employer?(____) yes (____) no

DSHS: Please present coupon

L & I: Claim Number _____Date of Injury_____

(____) State of Washington (____) Self Insured Address_____

**FINANCIAL AGREEMENT, EXTENSION OF CREDIT AND AUTHORIZATION FOR TREATMENT:**

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing.

In accordance with the Federal Truth-in-Lending Act which requires us to give our patients information in connection with extension of credit, please be advised of the following policies which apply in this clinic. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 60 days from the date of patient responsibility to pay 1% per month on the unpaid balance (annual rate of 12%) with a minimum charge $1 per month.
3. To pay cost and/or reasonable attorney for collection or suit.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original.

Signature of Responsible Person_____Date_____

**MEDICARE PATIENTS ONLY – LIFETIME AUTHORIZATION:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the physicians of South Sound Surgical Associates for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____Date_____