SUMMIT THERAPY & HEALTH SERVICES

CENTERED ON EXCELLENCE

Adult Patient Information

Today's Date: _____

Name: _____ Date of Birth: _____/_____/_____
(Last) (First) (M.I.)

Local Address: _____
(Street) (City) (State) (Zip)

Billing Address: _____
(Street) (City) (State) (Zip)

Home/Mobile Telephone Number: _____ Work Telephone Number: _____

Social Security #: _____-_____-_____ Sex: Male☐ Female☐

Married: Yes☐ No☐ Unknown☐

Would you like to be reminded of appointments? ☐ Phone call ☐ Text ☐ Email ☐ No Thanks

Patient Email (for appointment reminders): _____

Primary Physician: _____ Referring Physician: _____

Is this ☐ **Work Related** ☐ **Auto accident** Claim #: _____ Date of Injury: _____

Insurance Co.: _____Claim Manager: _____ Phone: _____

Patient's Employer: _____ Employer's Phone #: _____

Employer Address: _____
(Street) (City) (State) (Zip)

Person to Notify in Case of Emergency: _____

Address: _____
(Street) (City) (State) (Zip)

Relationship to Patient: _____ Phone #: _____ Work #:_____

Insurance: Please provide us with your card so that we can make a copy of it. If you are not the insurance subscriber please fill in:

Subscriber: _____Subscriber DOB: _____

Subscriber Social Security: _____-_____-_____

Revised: 04.06.17

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Consent to Treatment, Promissory Note, and Authorization to Pay Medical Benefits

1. I, the patient named below, have been informed of the nature and purpose of any treatment and procedures and am aware of the risk and medical complications that may occur. I understand and acknowledge that no guarantee or assurance has been made as to the results that may be obtained. I voluntarily consent to care, treatment, and related procedures.
2. I understand that Pullman Regional Hospital will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law. If applicable, I have given consent to Pullman Regional Hospital billing staff to discuss the hospital bill with my parents or legal guardian.
3. Screening or treatment will not be delayed by your refusal to pay. I understand that I may receive a bill from Pullman Regional Hospital, and possibly separate bills from individual physicians or other organizations for any services performed. This may include charges from specialists. Should the account be left unpaid, the account will be referred for collection. The undersigned shall pay all court costs, reasonable attorney fees and collection expense. Pursuant to RCW 60.44.020 and 1503-S.SL, patient is hereby notified that Pullman Regional Hospital at its discretion may utilize the practice of filing hospital liens as authorized under Washington law. It is agreed by the parties involved that Washington has jurisdiction and that venue in any action taken to collect this account may be in Whitman County, Washington, Superior Court or Whitman County, Washington, District Court, at the option of Pullman Regional Hospital.
4. I understand that among those who attend patients at this hospital are health care personnel in training who, unless requested otherwise, may be present during patient care.
5. Medicare certification/payment: If I am applying for payment under Medicare/Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the organizations furnishing the services or authorize them to submit a claim to Medicare/Medicaid.
6. I understand that repeated failure to attend scheduled appointments without prior notice may result in cancellation of future appointments and discharge from therapy.
7. This consent will expire 90 days from the below date or the end of treatment, whichever is later.

Pullman Regional Hospital does not discriminate on the basis of age, sex, sexual preference, marital status, race, religion, creed, color, national origin, source of payment, or the presence of any sensory, mental, or physical handicap. The patient or authorized representative has read this form and is satisfied that he/she understands its content and significance.
Pullman Regional Hospital keeps a record of the health care services we provide you. You may ask to see and copy that record (copy fees apply). You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Health Information Management. The hospital's Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed and how you can access your information. Pullman Regional Hospital encourages patients to read this policy in full. Changes to this policy will be posted on our website at www.pullmanregional.org. **I acknowledge a copy of the hospital's Notice of Privacy Practices, Patient Rights and Responsibilities, Financial Assistance Summary has been offered to me. _____**

_____
Patient Name

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Patient's Guardian/Representative Date Relationship to Patient

_____ _____
Hospital Representative Signature Date

Revised: 04.06.17