

ADVANCED ORTHOPAEDIC INSTITUTE

Office of JEFF CARTWRIGHT, M.D.

103 E. Third St

Arlington, WA 98223

360-403-0333 360-403-0331FAX

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**PATIENT REGISTRATION FORM & FINANCIAL PAYMENT POLICY**

Today's Date: \_\_\_\_\_

**Patient Info: Please print**

Name \_\_\_\_\_ DOB \_\_\_\_\_

SSN \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ wk/ cell

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_

Emergency Number \_\_\_\_\_ Family/Primary Physician \_\_\_\_\_

Referred by? \_\_\_\_\_

Marital Status: Single \_\_ Married \_\_ Other \_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

is this injury job-related? Yes \_\_ No \_\_ where did injury occur? \_\_\_\_\_

\*\*\*\*\*

**Guarantor Info: (person responsible for bill and/or primary person on insurance account)**

Same as above: \_\_\_\_\_ Spouse: \_\_\_\_\_ Parent: \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

SSN \_\_\_\_\_ Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ wk/ cell

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

INSURANCE INFO	PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance Company		
L&I Patients: Date of Injury		
Subscriber's Name		
Subscriber's Employer		
Subscriber's ID Number		
Subscriber's Group Number		
Subscriber's DOB & Sex: M or F		
Subscriber's Address & Phone if different from patient or guarantor		
Relation of Subscriber to Patient		

**\*\*\*Co-pays must be paid at time of service. See office policies.**

**\*\*\*Patients without insurance will be required to establish a payment plan with our office. Payment plans also require a copy of the debit/credit card you will be using.**

The above information is true to the best of my knowledge. I authorize the physician and clinic to release any information to process insurance claims. I also authorize my insurance to be paid directly to the clinic. I understand that I am ultimately responsible for charges associated with medical services provided by this office and agree and guarantee to pay all bills within 30 days from the receipt of statement, unless other arrangements are made with this office. I further agree to pay any attorney's fees, court costs, and related collections fees incurred as relating to my account. All unpaid balances over 90 days will be sent to a collections agency and will be subjected to an interest rate set by the collection agency.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

***FOR MEDICARE BENEFICIARIES ONLY: PLEASE READ & SIGN***

I request payment of authorized Medicare benefits be made on my behalf for any services furnished to me by or in clinic of Jeff Cartwright MD/Advanced Orthopaedic Institute. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_