



66 N. 6th St
Pomeroy, WA 99347

**PLEASE COMPLETE
ALL AREAS**

REGISTRATION FORM

Thank you for allowing us to serve you today. It is our goal to provide quality customer care. It is also our goal to process your claim in a very timely and accurate manner. In order to reach that goal, each visit, we will need to:

Obtain a copy of your insurance card(s) including auto insurance if you are here for an auto accident, and collect your co-pay.

Lab	X-Ray	Inpatient	Obsv	Clinic	ER	PT	Massage	Attending Physician	
Work Injury? Yes No		Was injury reported to your supervisor? Yes No			Accident? Yes No		Type of Accident	Time of Accident	Place of Accident
Patient's Legal Last Name				First Name			Middle Name	Social Security #	
Date of Birth	Age	Gender (circle one) Male Female		Driver's License # & State Issued				Marital Status	
Home Street Address						City	State	Zip	
Home Phone (include area code)			Cell Phone			Work Phone			
Patient's Employer									
Employer's Address						City	State	Zip	
Who is Financially Responsible for Services?		Last Name		First Name		Middle Name	Social Security #		
Relationship to Patient			Employer						
Employer's Address						City	State	Zip	

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

CONSENT TO MEDICAL AND SURGICAL PROCEDURES: The undersigned consents to the procedures which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services, and which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or hospital services rendered the patient under the general and special instructions of the patient's physician or surgeon.

RELEASE OF INFORMATION: The Hospital may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract, or otherwise responsible, to the Hospital or to the patient or to a family member or employer of the patient for all or part of the Hospital's charges, including but not limited to, Hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent or as patient, that in consideration of the services to be rendered to the patient he hereby individually obligated himself to pay the account of the Hospital. I understand that if the charges are covered by insurance of any type, it is nevertheless my personal obligation to pay for all charges billed. If I have been injured in an accident, I agree to pay the charges, at the time of Service, rather than postpone payment until any claim for damages has been settled. I understand that Garfield county Hospital District is a non-profit organization and that it may act as billing Agent for the emergency room physicians, radiologist and pathologists. I agree to pay interest at the legal rate should the account become delinquent, and if it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney's fee and collection expense.

MEDICARE ASSGNMENT OF BENEFITS: If applicable, I certify that the information given by me in applying for payment under Title XVIII (Medicare) of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Socual Security Administration, or its intermediaries or carriers, any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Garfield County Hospital District of Insurance benefits otherwise payable to me for payment of hospital services, but not to exceed the Hospital's regular charges. It is agreed that payment to the Hospital pursuant to this authorization, by an insurance company, shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I understand that the Hospital does not accept responsibility for collecting my insurance proceeds or negotiating a settlement on a disputed claim. It is also understood that I am financially responsible for charges not covered by this agreement.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I received the Privacy Practices Notice of Garfield County Public Hospital District No. 1.

FACILITY DIRECTORIES (Applicable if patient is an inpatient or in a bed): Unless you object, you may be included in our facility directory, which may include your name, medical condition, religious affiliation, and your location in our facility. Please be aware that if you object, you will receive no deliveries and anyone calling for information will be told we have no information on this person. To object, please initial here _____.

I HAVE READ THIS AND FULLY UNDERSTAND THIS FORM:

X _____ Date _____ Time _____
Parent / Patient / Guardian / Conservator

If other than a patient, indicate relationship

Witness / Staff – Print Name & Signature

**REQUIRED
STAFF CHECK LIST
(initial when complete)**
Copy of Medical Insurance Card(s)

Copy of Auto Ins Card

Collected Co-Pay
