KVH
Kittitas Valley Healthcare
Your Home for Health

Patient Registration Form

PATIENT INFORMATION				
Patient's Last name:	First Name:	Middle:	Nickname:	SSN:

Birth date:	Gender: ☐ M ☐ F	Former Name(s):	How would you like to be contacted for reminders?: ☐Call ☐Text ☐Email
Mailing Address:		Physical Address:	
City:		State:	Zip Code
Home Phone: ( )	Preferred Daytime Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Email Address:		Primary Care Physician/Practitioner:	
Marital Status (circle one) : Single / Married Divorced / Separated / Widowed / Life Partner	Race/Ethnicity: Declined ☐		Preferred Language:
Mother's Name (if patient is a minor)	Father's Name (if patient is a minor)		

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home Phone : ( )	Work Phone: ( )

INSURANCE INFORMATION	
Name of Primary Insurance Company:	Name of Insured: Insured DOB: / /
Employer:	Relationship of Insured to Patient (circle one): Self / Spouse / Parent / Other: _____
Name of Secondary Insurance Company (if applicable):	Name of Insured: Insured DOB: / /
Employer:	Relationship of Insured to Patient (circle one): Self / Spouse / Parent / Other: _____

AUTHORIZATION & ASSIGNMENT

Notification for release of payment:
I request that payment of authorized Medicare and insurance benefits be made to my healthcare provider for any services furnished to me by this medical staff. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services (CMS) and its agents or to my other insurance companies any information needed to determine these benefits. I authorize treatment of the person named above as the Patient and agree to pay all fees and charges for such treatment, and I accept financial responsibility for services and supplies rendered.

Financial Agreement:
I understand that copayments are due at the time of service. I assign payment from my insurance companies directly to Kittitas Valley Healthcare. I understand that I am financially responsible to Kittitas Valley Healthcare for the charges not paid by insurance and that payment is due within 30 days of invoice. I understand that in addition to the bill from my provider, I may also receive separate bills for laboratory, radiology, and other specialized services.

Receipt of notice of health information practices:
I acknowledge that I have been provided a copy of the Kittitas Valley Healthcare **Notice of Health Information Practices** which provides information about how my health information may be used and disclosed.

I have read the above and understand its contents.

Patient/Guardian signature:	Date:

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Please place patient label here

Family and Friends Authorization

This form authorizes KVH clinics to share verbal or written medical information with third parties, e.g., family members, caregivers. It is NOT an authorization to release medical information to other physicians and / or attorneys.

I, _____, DOB _____, authorize KVH
(Name of Patient)
clinics to discuss information regarding my health with the following person(s):

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

Please initial below what information may be shared.

_____ I authorize that **all test results** be shared.

_____ I authorize my **entire medical record** be shared.

_____ I authorize my **financial information** may be shared.

Please initial below your preferences for phone contact.

_____ I hereby give permission to KVH clinics to *leave messages on my voice mail/answering machine* regarding appointment confirmations, scheduling changes, and/or referral information.

_____ I hereby give permission for KVH clinics to *leave a message with my spouse and/or other person(s)* regarding appointment confirmations, scheduling changes and/or referral information.
Name of individual(s) who this information can be left with is: _____
_____
_____

_____ I specifically want KVH clinics to ***exclude*** the following protected health Information from disclosure: _____
_____
_____
_____

This authorization will remain in effect indefinitely. I can rescind this authorization at any time with written notification.

X_____ _____
Signature of Patient or Guardian **Date Signed**

_____
Relationship or status, if signed by anyone other than patient

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Authorization for Release of Information

Patient Name:		Other Names:
DOB:	SSN:	Phone: ( )

Please release my healthcare information as directed.

FROM:	**TO:**
Provider Name:	Provider Name:
Facility Name:	Facility Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone #/Fax #	Phone #/Fax #

Reason for release of records:

☐Transfer of Care ☐Provider Request ☐Personal ☐Other:_____

Information to be released:

☐All health records in the last 2 years unless otherwise specified (chart notes, labs, x-rays, tests, etc.)

☐All health records relating to the following condition(s):_____

_____

☐All health records for the date specified: FROM: _____/_____/_____ TO: _____/_____/_____

☐Other:_____

Please EXCLUDE the following information from the records released (please initial):

_____Drug/Alcohol abuse/treatment _____Sexually transmitted diseases

_____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric diagnosis/treatment

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or health care operations). I may revoke this authorization at any time and only in writing by following the process listed in the Notice of Privacy Practices. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED AGENT DATE

_____ _____

Relationship of status if signed by anyone other than the patient Expiration Date

***Please provide documents to prove authority to sign on patient's behalf**