KVH
Kittitas Valley Healthcare
Your Home for Health

KVH Workplace Health Patient Registration Form

PATIENT INFORMATION

Patient's last name	First name	Middle	Nickname	SSN

Birth date	Gender	Former Name(s)	How would you like to receive reminders?
	☐ F ☐ M		☐ Call ☐ Text ☐ Email

Mailing address:		Physical address:	

City:		State:		Zip code:		

Home Phone	Daytime Phone	Work Phone	Cell Phone	Preferred Phone

Email address:		Primary care physician/practitioner:	

Marital status	Race/Ethnicity	Preferred language

Mother's name (if patient is a minor)	Father's name (if patient is a minor)

EMERGENCY CONTACTS

Name	Relationship to patient	Home phone	Work phone

INSURANCE

Primary Insurance Company	Name of insured	Insured DOB

Employer	Relationship of insured to patient	

Secondary Insurance Company	Name of insured	Insured DOB

Employer	Relationship of insured to patient	

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	