KVH
Kittitas Valley Healthcare
Your Home for Health

Patient Registration Form

PATIENT INFORMATION					
Last Name:	First Name:	M.I.	Preferred Name:	SSN:	Date of Birth:

Current Sex:	Birth Sex:	How would you like to be addressed?	Preferred Language:
☐M ☐ F ☐ Unknown	☐M ☐F ☐ Unknown	☐He/Him/His ☐She/Her/Hers ☐They/Them/Theirs ☐_____	

Mailing Address:	Physical Address:

City:	State:	Zip Code:	City:	State:	Zip Code:

Home Phone:	Cell Phone:	Work Phone:	Extension:
( )	( )	( )	

Email Address:	Send Patient Portal Invite? ☐ Yes ☐ No	Primary Care Practitioner:

Marital Status (circle one): Single / Married / Divorced / Separated / Widowed / Life Partner	**Race(s):** Alaska Native / Asian Indian / Black or African American / Chinese / Filipino / Guamanian or Chamorro / Hispanic / Japanese / Korean / Native American / Native Hawaiian / Pacific Islander / Other Asian / Samoan / Spanish / Vietnamese / White / Unknown / Other:	**Ethnic Group(s):** Puerto Rican / Hispanic or Latino / Mexican or Mexican American / Cuban / Not Hispanic or Latino / Unknown

Parent(s)/Guardian(s) (if patient is a minor):	Employer:

IN CASE OF EMERGENCY			
Name:	Patient Relationship to Contact:	Primary Phone : ( )	Work Phone: ( )

INSURANCE INFORMATION	
Primary Insurance Plan:	Name of Subscriber: Insured DOB: / /
Member ID:	Relationship of Patient to Subscriber (circle one): Self / Spouse / Child / Other: _____
Secondary Insurance Plan (if applicable):	Name of Subscriber: Insured DOB: / /
Member ID:	Relationship of Patient to Subscriber (circle one): Self / Spouse / Child / 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 co-payments 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 Privacy Practices:
I acknowledge that I may request a copy of the Kittitas Valley Healthcare **Notice of Privacy Practices** which provides information about how my health information may be used and disclosed. A copy of the Notice is posted at this location.

I have read the above and understand its contents.

Patient/Guardian Signature:	Date:

Sharing Information with Family and Friends

This form authorizes KVH Clinics to share verbal or written medical information with family members and caregivers. It is **NOT** an authorization to release copies of medical records and/or diagnostic images.

I, _____, _____, authorize _____

Patient Name **Date of Birth** **Name of KVH Clinic**

to discuss information as listed below with the following person(s):

Name	Relationship	Test Results	All Health Information	Financial Information
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
		☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

I specifically want the KVH Clinic to ***exclude*** the following protected health information from disclosure to those listed.

(√)		(√)	
	Substance Use		Other:
	Mental Health		
	STD/Reproductive Health		

Phone Contact Authorization

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

____ I hereby give permission for KVH Clinic *to leave a message* ***with my spouse and/or other person(s) listed below*** regarding appointment confirmations, scheduling changes and/or referral information.

Name of person(s) with whom this information may be shared:

I understand that KVH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. This authorization will remain in effect for one year from the date signed. I may revoke this authorization in writing at any time, except to the extent that action has already been taken.

_____ _____

Signature of Patient (Children over 13 years must sign for themselves) **Date Signed**

_____

Relationship or status, if signed by anyone other than patient

AUTHORIZATION TO RELEASE INFORMATION

I give Kittitas Valley Healthcare permission to ☐ **Release/Send Records to:** ☐ **Obtain/Request Records from:**

Name/Organization: _____ Specialty: _____

Address: _____ Phone#: _____

City, State, Zip: _____ Fax#: _____

The records of:

Patient Name: _____ Other Names: _____

Date of Birth: _____ Phone: _____

Information to be released:

☐ Health records relating to the following condition(s):_____ ☐ Office Visit Notes

☐ ER Records ☐ Lab/EKG ☐ History & Physical ☐ Discharge Summary ☐ Operative Report ☐ Imaging

☐ ALL Patient Records from the last: 2 years 5 years 10 years ☐ Other _____

Reason for release of records:

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

Please EXCLUDE the following information from this request. Please check those that apply.

☐ Drug/Alcohol abuse/treatment ☐ Sexually transmitted diseases

☐ HIV/AIDS diagnosis/treatment/testing ☐ Mental Illness or Psychiatric diagnosis/treatment

I understand that KVH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may revoke this authorization in writing at any time, except to the extent that action has already been taken. 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 Legally Responsible party **Relationship** **DATE**

This authorization expires 90 days from the date signed or on the following day/event:

ONE COPY OF THIS AUTHORIZATION MUST BE PROVIDED TO THE PATIENT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

HIM-02 (2/2018)

PATIENT NAME:

DOB:

FIN: