Phoenix Alexander
36511 32nd Ave S
Auburn, WA 98001
Phone 253-838-3336 Fax 253-838-3336

Alpine Therapeutic Massage
REGISTRATION FORM

(Please Print)

(Please give all appropriate insurance cards to the receptionist.)

Today's Date:	PCP:

PATIENT INFORMATION

Medicare ☐	Medicaid ☐ Champus ☐ Champva ☐	Group Health Plan ☐	FECA Blk Lung ☐	Other ☐	Insured's I.D. #:

Patient's name (Last, First, Middle Initial):	Birth date (MM/DD/YY):	Sex:		
		M: ☐ F: ☐		Insured's Name (Last, First, Middle Initial
Street Address:	Patient relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other ☐			Insured's Address:
City: State:	Patient Status: Single ☐ Married ☐ Other ☐			City: State:

Zip Code:		Employed ☐	Full time ☐ student	Part-time ☐ student	Zip Code: Telephone:
Telephone:	Should Phoenix Alexander need to contact you for any reason may we leave a voicemail or mail you correspondence: Yes ☐ No ☐	Is the Patient Condition Related to:			( )
( )		Employment:	Yes ☐	No ☐	Insured Policy Group or FECA number:
Mobile Phone:		Auto Accident:	Yes ☐	No ☐	
		If Yes, Date:		Place (state):	
( )		Other Accident:	Yes ☐	No ☐	Insured Birth Date: Sex
		If Yes, Date:			M: ☐ F: ☐

Email Address:	Date of Injury:	Employer Name or School Name:	
Employer:	Referring Provider:	Insurance Plan Name or Program Name:	
Work Number:	Spouse's Name:	Is there another Health Benefit Plan?	
( )		Yes ☐ No ☐	If **Yes**, fill out information Below.

ADDITIONAL HEALTH BENEFIT PLAN INFORMATION

Other Insured's Name (Last, First, Middle Initial):	Other Insured's Policy or Group Number:	Other Insured DOB:	Sex: M: ☐ F: ☐
Employer's Name or School Name	Insurance plan Name or Program Name	Reserved for Local Use:	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge.

X _____ _____

Patient/Guardian signature *(I have read and agree to the above statements)* *Date*

Assignment of Benefits:

To Insurance Company/ Attorney: I, _____, the patient or guardian, hereby direct and instruct you to make payment directly to Phoenix Alexander for medical claims submitted by her on my behalf for medically necessary treatment.

Patient Initials _____

Insurance Payment Agreement:

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that the office of Phoenix Alexander is willing to prepare the necessary reports and assist me in collecting from the insurance company the payment which is due to her for my medically necessary care and treatment.

I agree and acknowledge that I am ultimately responsible to Nancy Haller for payment of any balance due, including unpaid deductible and/or unpaid percentage amounts due to her according to my policy coverage, in the event she is unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf.

Attorney: *If I have retained an attorney,* it is understood that should it be agreed that the office of Phoenix Alexander, carried my account until settlement, then interest shall be charged at an annual rate of ____**PERCENT** and shall be accrued on a monthly basis of ____**PERCENT** per month. I agree that I am responsible for making sure interest charges are paid in full upon receiving my portion of the settlement.

Non-Payment by Patient: Payment not received in a timely manner will be turned over to an outside collection agency. If this occurs, in addition to my balance will include interest charges as stated above, I agree to also be held responsible for an additional amount of up to ____ **PERCENT** of my unpaid balance. This charge is for compensation of charges incurred by the collection agency on behalf of Nancy Haller.

Patient Initials _____

I understand that 48 hours notice is required for cancellation and 24 hours of notice is required for a reschedule. I understand that I will be charged for missed appointments without proper notice at up to 100% of the normal rate.
I understand that at the discretion of Phoenix Alexander I may elect to be billed monthly or at the time of each visit for the balances due to you from each visit.

Patient Initials _____

Patients' Name_____

Patients' Signature_____ Date _____

Providers' Signature _____ Date _____