PATIENT REGISTRATION FORM (CT WOOLLEY, MD)

1. PATIENT AND RESPONSIBLE PARTY

First Name Middle Initial Last Name

Responsible Party other than self

Address

City	State	ZIP

Birth Date (MM/DD/YYYY)	Gender ☐ M ☐ F	Language/ Race/ Ethnicity

Emergency Contact , Relationship and Phone

Social Security Number	Driver's License Number	

2. CONTACT INFORMATION

Home Phone ☐ Day ☐ Eve

Cell Phone ☐ Day ☐ Eve

Work Phone ☐ Day ☐ Eve

Fax

Email

At which contact number may we leave messages for you?

☐ Home ☐ Cell
☐ Work ☐ Email

3. PRIMARY INSURANCE

Name of the Insured	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Insurance Company	Insured's Birth Date	Insured's Social Security Number

Subscriber ID/Policy Number	Group ID	Insurance Company Contact Number

4. SECONDARY INSURANCE

Name of the Insured	Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Insurance Company	Insured's Birth Date	Insured's Social Security Number

Subscriber ID/Policy Number	Group ID	Insurance Company Contact Number

5. PATIENT'S PHYSICIANS / 6. PATIENT PHARMACY

Referring Provider	Family Doctor (PCP)	Pharmacy
Phone	Phone	Phone
Fax	Fax	Fax

7. EMPLOYMENT INFORMATION

Employer/School/Occupation	How long have you been with this employer or school?

8. PERSONAL INJURY/MOTOR VEHICLE ACCIDENT (MVA) CLAIM OR WORKERS COMPENSATION

If an accident, how did it happen? ☐ Auto ☐ Motorcycle ☐ Sport ☐ Slip and Fall ☐ Work		Date of injury or loss?
Case manager or Claim Adjuster's Name		What is your policy or claim number?
Case Manager or Claim Adjuster's Phone	Case Manager or Claim Adjuster's Fax	Case Manager or Claim Adjuster's email
Attorney's Name		Attorney's Phone Number
Attorney email		Attorney's Fax Number

We require written authorization or you must fill out the 827 claim form to file a new worker's compensation claim. Be aware that if your carrier denies the claim, your other insurance, or yourself will be billed directly.

C T WOOLLEY MD PC PATIENT REGISTRATION FORM

9. AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize release of medical information necessary to process this (these) insurance claim(s) and permit the following to be used in place of this original document for all federal, state, commercial, compensation, or liability insurance claims: (1) a photocopy of other facsimile reproduction of this authorization, (2) use of a computer to indicate my signature is on file at clinic, and/or (3) use of a computer to electronically transmit my claim for processing.

14. AUTHORIZATION TO ASSIGN MEDICAL BENEFITS TO CLINIC

I certify that information provided relative to injury, illness, and insurance coverage is both true and correct. I authorize payment of insurance benefits or proceeds from any liability claim and legal/court settlement to be assigned to the physicians of this practice to the extent that their charges are paid in full. I direct my insurance carrier that a photocopy of this authorization shall be considered a valid assignment of benefits in lieu of the original.

15. ACKNOWLEDGEMENT OF INSURANCE LIMITATIONS

Many insurance carriers require a written referral from a primary care physician (PCP) in advance of service (office visits, surgery, and diagnostic tests—MRI). Patients, parents, or the guardians are responsible for: (1) obtaining physician referrals, and (2) contacting their insurance carrier to verify benefits in advance of service. Patients are also responsible for non-covered services, deductibles, co-insurance, and any penalties imposed by their insurance company on our physician for seeing patients out-of-network. Co-payments are due at time of service.

16. ACKNOWLEDGEMENT OF CREDIT POLICY

I agree to be bound by the following terms: Payment is due within ten (10) days of the billing date, after which interest may be added to the unpaid balance at the rate of one and one half percent per month (18% per annum) until paid in full. In the event this account is turned over to a collection agency or attorney for collections, I shall additionally pay all costs of collections, including reasonable attorney's fees. We accept cash, checks, Mastercard, or VISA for payment.

17. ACKNOWLEDGEMENT OF PAYMENT RESPONSIBILITY

I authorize payment of medical benefits for any services to me by Charles Todd Woolley MD, to be paid directly to Charles Todd Woolley MD PC. I understand that I am responsible for any amount not covered by my insurance of all allowed charges. Therefore, I understand that this practice cannot accept responsibility for collecting or negotiating settlement on any disputed (1) health insurance claim, (2) worker's compensation claim, (3) accidental injury/illness liability claim, (4) claim where patient is/will be represented by an attorney, and/or (5) claim to be settled in a court of law.

I certify this information is true and correct. Under federal law, it is mandatory that you tell our office if you know that another party is responsible for paying for your treatment; Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

Patient's or Responsible Party's Signature	Date

18. ACKNOWLEDGEMENT AND CONSENT OF NOTICE OF PRIVACY PRACTICES

I understand that C T Woolley MD PC will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.
Make decisions about and plan for my care and treatment;

Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;

Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and

Perform various office, administrative, and business functions that support my physician's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how this practice will handle health information regarding me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosure of health information made and the information practices followed by the employees, staff, and other office personnel of this practice, and my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I also understand that a copy or a summary of the most current version of this notice will be posted in the reception area. I further understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that this practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

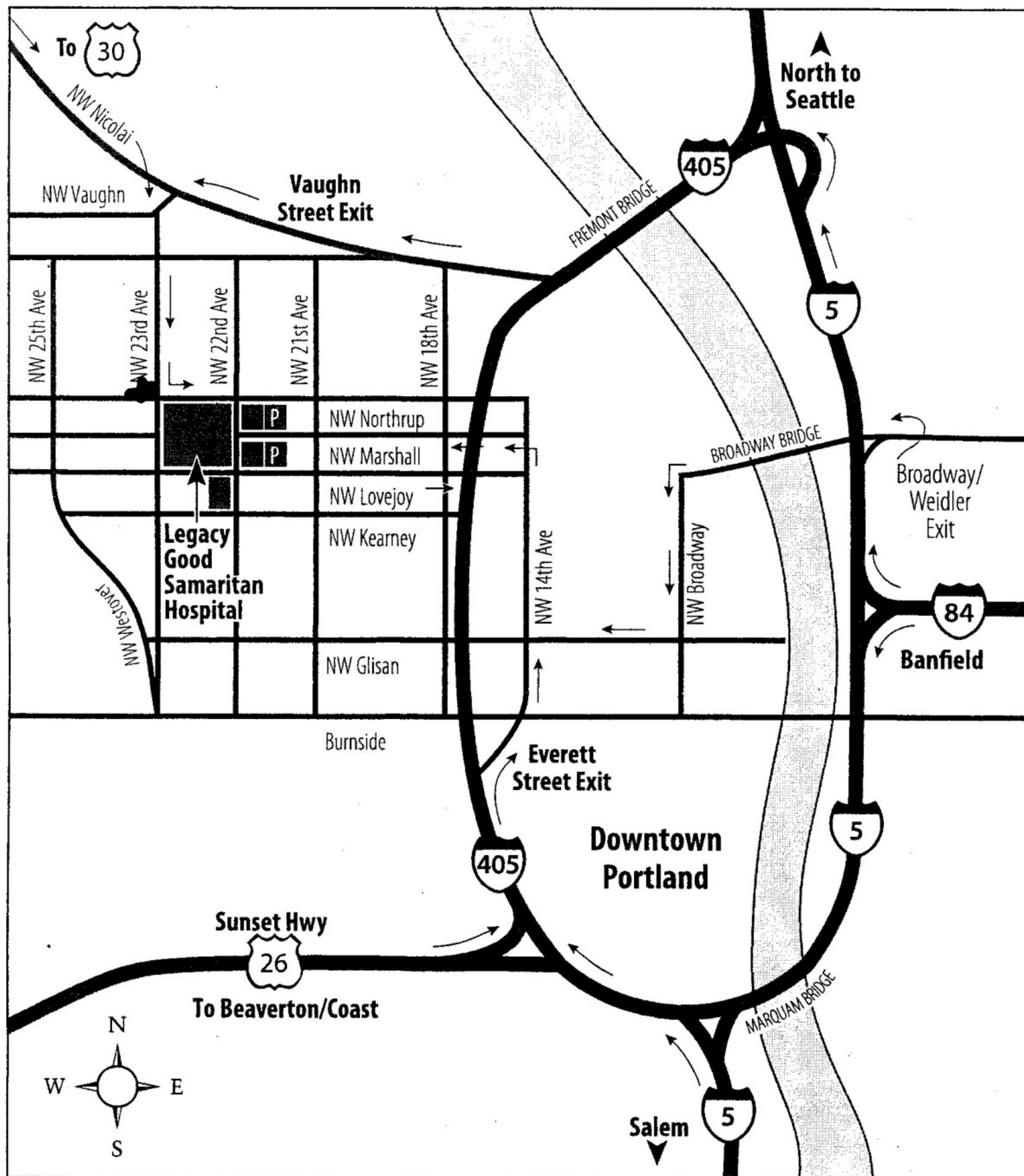
Patient's or Responsible Party's Signature	Date

From the North:
*Travel South on I-5
*Take Exit 302B (I-405 South Beaverton/St. Helens)
*Cross the Willamette River on Fremont Bridge,
Stay to the right and take Exit 3 (Vaughn St.)
*Turn left on NW 23rd Avenue (first light after Vaughn St. exit)
*Turn right on NW Northrup (Northrup Center located on corner of NW 23rd & Northrup

From the South:
*Travel North on I-5
*I-5 splits near downtown, stay left
*Follow signs to I-405 / City Center/Beaverton (Exit 299B)
*Take Exit 2B (Everett St.) onto 14th St.
*Turn left on NW Glisan
*Turn right on NW 21st
*Turn left on NW Northrup
*Cross over NW 23rd and Northrup Center will be on the right hand side on the corner of 23rd and Northrup

From the East – I-84:
*Travel West on I-84
*Follow signs to I-5 (right lanes)
*Follow I-5 North to Exit 302B
*Take Exit 302B across the Fremont Bridge
*Stay to the right and take Exit 3 (Vaughn St.)
*Turn left on NW 23rd Avenue (first light after Vaughn St. exit)
*Turn right on NW Northrup (Northrup Center located on corner Of NW 23rd & Northrup

From the West:
*Travel East on US 26/Sunset Highway
*Exit on I-405 (Seattle/St. Helens)
*Take Exit 2B (Everett St.) onto 14th St.
*Turn left on NW Glisan
*Turn right on NW 21st
*Turn left on NW Northrup
*Cross over NW 23rd and Northrup Center will be on the right hand side on the corner of 23rd and Northrup



Parking for Northrup Center:
Located on NW Northrup - 1st driveway on the right just past our building

C. TODD WOOLLEY, MD
JERRY E. NYE, MD
Northrup Center
2311 NW Northrup
Suite 209
Portland, OR 97210
503-274-4865
503-274-4989 (fax)