Patient Registration

Angela Heithaus MD, specializing in Adult ADHD

FirstName:____________________________ **Last Name:**__________________________________

Street Address:____ **City:**_______________________

State__________ **Zip:**________________ **email:**____

Cell Ph:____________________________ **Alt. ph:**____

Date of Birth:_____________________ **Gender:** M F **SSN:**________________________

Referred By: _____________________________________

Auto-pay (optional)**: cc #**______________________ **expiration**_________ **ccv code**_______

Primary insurance

Insurance company name:___________________________ **Phone:**____________________

Subscriber's Name_________________________ **DOB:**___________ **SSN:**_______________

Relationship to you:__________________ **ID#**_________________ **Group#**______________

Secondary insurance: ____

Patient consent & release

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to Angela Heithaus MD. I authorize the release of any information required to process my claim to the necessary insurance companies, third party payers, and/or other physicians or health care entities required to participate in my care. I agree that I am financially responsible for all services provided.

Initials_______

Financial policy

Our office is committed to providing quality and cost-effective healthcare to our patients. Insurance reimbursement is a contract between you an your insurance company. It is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment. It is your responsibility to understand the limits and restricts affecting coverage of services you receive. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pay, deductibles and coinsurance amounts not covered by your insurance policy along with the entire amount of any non-covered service. Patient who do not have insurance coverage (or proof of coverage) or who choose to pay for covered services are expected to pay in full at the time of service. For your convenience we accept cash, personal check, Visa and MasterCard.If your personal check is returned by the bank due to *Insufficient Funds,* a fee will be charged. Fees will also be assessed for failure to keep scheduled appointments, or failure to cancel with at least 24 hours notice. We realize that healthcare is sometimes an unplanned event, so we will attempt to accommodate your needs as circumstances require. Please call our office at 206 428 2080 with any questions you may have regarding our financial policy and procedures.

Initials_______

I have read and understand the above policies:

Patient Signature ___________________________ Date: ____________________

1836 Westlake Ave N, suite 303, Seattle, WA 98109
Phone 206-428-2080 | Fax 206-350-6697 | frontdesk@drheithaus.com | drheithaus.com