WATSON CLINIC LLP

Quality Healthcare for Every Generation

WATSON CLINIC #

☐☐☐☐☐☐☐☐☐☐

☐ New Patient
☐ Legal Name Change
☐ Insurance Change
☐ Guarantor Change
☐ Address Change
☐ Other

PATIENT REGISTRATION FORM

PLEASE PRINT

Last Name:	First:	Middle:	Date of Birth:	Social Security #:

Billing Address:	Apt./Lot:	City:	State:	Zip:

Primary Phone #: Type: ☐ Cell ☐ Land ( )	Alternate Phone(s) #: Type: ☐ Cell ☐ Land TTY ( )	Secondary ( ) Fax ( )	Preferred Method of Notification: ☐ Primary Phone ☐ Alternate Phone ☐ Billing Address

Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated	Primary Language:	Please Indicate Special Needs: ☐ Language Translator ☐ Blind/Visually Impaired ☐ Deaf/Hearing Impaired ☐ Other_____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander	Ethnicity: ☐ Hispanic or Latino or Spanish Origin ☐ Not Hispanic or Latino or Spanish Origin

Maiden/Previous Legal Name(s):	Mother's Current and Maiden Name, if Minor Patient:	Father's Name, if Minor Patient:

Occupation of Patient:	Employer/Company Name:	Employer Address:	Employer Phone #: ( )

Spouse's Name:	Spouse's Employer:	Spouse's Employer Address:	Spouse's Employer Phone #: ( )

Name of Person Outside of Home to Contact in Case of Emergency:	Emergency Contact Address:	Emergency Contact Phone #'s: Home ( ) Work ( )	Relationship to Patient:

If this form represents a change to your clinic account, please list names of family members whose records will need to be updated also.

Name	Sex	Birthdate	Name	Sex	Birthdate
1.			3.		
2.			4.		

INSURANCE INFORMATION

Primary Insurance:	Effective Date:

Mailing Address:

City:	State:	Zip:

Subscriber's Name:	Subscriber's Employer:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Life Partner ☐ Dependent Child ☐ Other	Subscriber's Sex: ☐ Male ☐ Female	Subscriber's Birthdate:

Policy #:	Group #:

Secondary Insurance:	Effective Date:

Mailing Address:

City:	State:	Zip:

Subscriber's Name:	Subscriber's Employer:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Life Partner ☐ Dependent Child ☐ Other	Subscriber's Sex: ☐ Male ☐ Female	Subscriber's Birthdate:

Policy #:	Group #:

WATSON CLINIC LLP

WATSON CLINIC #

FINANCIAL AGREEMENT

Head of Household or Parent with Custody of Minor Child:			Relationship to Patient:		Responsible Party's Social Security #: – –
Mailing Address:	Apt./Lot:	City:	State:	Zip:	Responsible Party's Phone #: ( )
Responsible Party's Employer:	Employer's Address:	City:	State:	Zip:	Employer's Phone #: ( )
Responsible Party's Occupation:		Person Completing Form / Relationship to Patient:			

RESPONSIBILITY FOR PAYMENT

As a patient/guarantor, I agree to be responsible for payment of services upon receipt of statement according to the following guidelines:

- If there is no health plan coverage or I elect to self-pay for the medical services rendered, I will be responsible for payment at the time of service or I will establish payment arrangements with Watson Clinic LLP Business Office.
- If my medical plan does not have a contracted arrangement with Watson Clinic LLP, I will assume full responsibility for any account balance not paid by my plan. This is often referred to as being "out-of-network" or having an indemnity plan.
- If my health plan is contracted (participating) with Watson Clinic LLP, I agree to pay all applicable co-payments on date of service, as well as all deductibles, co-insurances and non-covered benefit charges.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION

I authorize payment from all applicable insurance carriers and payors directly to Watson Clinic LLP for the surgical and/or medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to physicians and/or other providers for services provided during my treatment. I request that payment of authorized Medicare, Medigap, and other benefits be made to Watson Clinic LLP, on my behalf in making this assignment. I understand and agree that I may be financially responsible to Watson Clinic LLP for charges not paid by my insurance policy(ies) and payors. I authorize Watson Clinic LLP to use and disclose my protected health information (PHI), including sensitive information related to mental health, substance abuse, HIV/AIDS, genetic testing, hospice care and other sensitive matters as needed for payment purposes. I permit a copy of this authorization to be used in place of the original.

Watson Clinic LLP will provide me with a copy of this form upon request.

_____ Patient Signature/Guarantor

_____ Insured's Signature (Parent/Legal Representative if applicable)

Date _____

WATSON CLINIC LLP

Quality Healthcare for Every Generation

WATSON CLINIC #

CONSENT

CONSENT TO TREATMENT

I consent to Watson Clinic LLP providing healthcare services and treatment to me. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic tests, radiology and laboratory procedures, medication administration, taking and utilizing cultures, administration of anesthetics, HIV testing, the creation, sharing, and storage of a record of my blood or biometric information for treatment purposes (such as a photograph of a retina), and other necessary tests, procedures and treatment. I understand that, except for emergency and extraordinary circumstances, certain procedures will not be performed without me being provided an opportunity to give informed consent for that procedure. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance. I understand that Watson Clinic LLP provides treatment in multiple locations, and I consent to receive treatment in any location where Watson Clinic LLP physicians or providers may treat me including the provision of care by any third-party providers as ordered or requested by Watson Clinic LLP. I understand that this consent is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

Initial here if you have read and agree to all of the above statements in this "Consent to Treatment" section: ***Patient or Patient Representative Initials*** _____

CONSENT FOR OBSERVERS/TRAINEES

As part of its health care operations functions, Watson Clinic LLP may conduct training programs in which students, health care practitioners, or others (collectively, "Trainees") may observe or participate in care. I agree that these Trainees may observe and participate in my care including, where appropriate, providing direct care to me under the supervision of Watson Clinic personnel.

Initial here if you have read and agree to all of the above statements in this "Consent for Observers/Trainees" section: ***Patient or Patient Representative Initials*** _____

PHOTOGRAPHS AND OTHER IMAGES

In the course of healthcare treatment, I agree that Watson Clinic LLP may take pictures and videos of me for identification, treatment, health care operations, and other lawful purposes, including those described in the Notice of Privacy Practices. Any pictures taken by Watson Clinic LLP while caring for me will be treated as part of the medical record and will be subject to applicable privacy law. Watson Clinic LLP will not take a picture of me in the course of my treatment for any other purpose; without my written permission.

EMAIL NOTIFICATION AND PATIENT PORTAL

Email address: _____

If I have provided my email address on this form or by a previous method, or if I have signed up for the Watson Clinic LLP patient portal, I agree to receive electronic notification of announcements and information from Watson Clinic LLP, including, but not limited to notices of data breaches, privacy notices, and other information. I agree to update my contact information with Watson Clinic LLP as necessary or inform Watson Clinic LLP in writing if I no longer wish to receive emails. I agree that certain emails that, in Watson Clinic LLP's judgment, are not of a particularly sensitive nature may be sent by unencrypted email, which has the potential to be intercepted by unauthorized persons.

Initial here if you have read and agree to all of the above statements in this "Photographs and Other Images" section: ***Patient or Patient Representative Initials*** _____

Signature: Watson Clinic LLP will provide me with a copy of this form upon request. I have received and read a copy of Watson Clinic LLP's HIPAA Notice of Privacy Practices ("Notice"). This consent applies to all of my protected health information (PHI), even if Watson Clinic LLP obtained it before or after I signed this form. By signing below, for the sections initialed above, I consent to and further authorize the use and release of my PHI as explained in the initialed sections of this form and the Notice. I consent to be contacted for the purposes described in the Notice, including for treatment, clinic operations, accounting, billing, payment, collection, and possible treatment alternatives and other health-related benefits and services that may be of interest. I CERTIFY THAT THE MEDICAL AND FINANCIAL INFORMATION I PROVIDE TO WATSON CLINIC LLP IS TRUE, COMPLETE AND ACCURATE IN EVERY RESPECT.

Patient/Patient Representative Name (PLEASE PRINT)	Date Signed
Signature	Relationship to Patient (if not signed by patient) ☐ Parent ☐ Legal Guardian ☐ Other (explain authority):