Olympia Respiratory Services • Puyallup Respiratory Services
Grays Harbor Respiratory Services • Tacoma Respiratory Services

PATIENT INFORMATION FORM

Completion of this information in its entirety is required at time of visit

A. Name _____ _____ _____ Social Security # ____-____-____
Last First Middle

Birth date ____/____/____ Gender: Male / Female
Mo Day Yr

Home Address _____ _____ _____ _____
Street City State Zip Code

Mailing Address _____ _____ _____ _____
Street City State Zip Code

Home Phone (____) _____-_____ Work Phone (____) _____-_____ Cell /Another Phone (___) _____-____

Email _____

B. In case of Emergency:

Relative to contact _____ Phone (____) _____-_____

Another Person to contact (not relative) _____ Phone (____) _____-_____

C. How do you intend to pay? Cash ____ Check _____ Credit Card ____ Insurance _____ Other ____

Primary Insurance Co. _____ Policy # _____ Group # _____

Secondary Insurance Co. _____ Policy # _____ Group # _____

D. History:

Primary Care Physician: _____ **Sleep Physician:** _____

Sleep Lab: _____ **Approximate Date of Sleep Study:** _____

Authorization of Benefits & Authorization to Treat

I authorize Olympia Respiratory Services, LLC to provide me with medical treatment per a physician's prescription. I authorize payment of insurance benefits on my behalf to Olympia Respiratory Services, LLC. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Olympia Respiratory Services to obtain medical and/or other information necessary to process my claim(s), including eligibility and seeking reimbursement for medical supplies provided. I authorize Olympia Respiratory Services, LLC to contact me by phone or mail regarding my medical supplies and treatment.

Signature _____ Date _____

1404 Harrison Ave NW
Olympia, WA 98502
360-236-0311 Office
360-236-1179 Fax

3773 Martin Way
#C102
Olympia, WA 98506
360-688-7669 Office
360-915-8572 Fax

954 Anderson DR
Suite 109
Aberdeen, WA 98520
360-637-9671 Office
360-637-9721 Fax

110 15th Ave
Puyallup, WA 98372
253-881-1337 Office
253-881-1737 Fax

1310 South Union
Avenue #B1
Tacoma, WA 98405
253-507-5683 Office
253-507-7793 Fax

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Patient Acknowledgement
Receipt of Privacy Notice

I hereby affirm that I have received a copy of the *Notice of Privacy Practices* from. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

I request the individuals listed below to be involved in my health care and authorize my medical information to be disclosed to them.

Name: _____

Name: _____

Name: _____

Name: _____

Consent to leave detailed voicemail

☐ I give my consent to the staff at Olympia Respiratory Services to release and/or leave messages regarding my care or equipment as necessary at: _____
(Phone Number)

☐ I do not consent to messages being left. Please contact me directly.

Patient Name: _____ **Date** _____

_____ _____
Signature of Patient or Personal Representative Name and description of Personal Representative (if applicable)

▼▼▼ FOR **OFFICE USE ONLY** ▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	