BILLING INFORMATION

PATIENT INFORMATION
Name: ____________________
Address: ____________________
City: __________ State: ______ Zip: __________
Phone: (H): __________ (W): __________
(Cell): __________ Email: __________
Date of Birth: __________ Male: _____ Female: _____
Marital Status: Married: _____ Single: _____ Partnered: _____
Relationship of Patient to Insured:
Self _____ Spouse _____ Partner _____ Child _____ Other _____
Patient's Social Security Number: __________
Is patient's condition related to? (Please circle one)
Employment _____ Auto Accident _____ Illness _____ Other _____

PRIMARY HEALTH CARE PROVIDER
Name: ____________________
Address: ____________________
City/State/Zip: ____________________
Phone: __________ Fax: __________

HEALTH INSURANCE INFORMATION
Insured (If other than patient)
Name: ____________________
Date of Birth: __________ Male _____ Female _____
Address: ____________________
City: __________ State: ______ Zip: __________
Phone: (H): __________ (W): __________
(Cell): __________ Email: __________

Primary Insurance:
Insurance Carrier: ____________________
Contact: ____________________
ID#: ____________________
Group#: ____________________
Billing Address: ____________________
City: __________ State: ______ Zip: __________
Phone: __________ Fax: __________

Secondary Insurance:
Insurance Carrier: ____________________
Contact: ____________________
ID#: ____________________
Group#: ____________________
Billing Address: ____________________
City: __________ State: ______ Zip: __________
Phone: __________ Fax: __________

WORKERS' COMPENSATION
Employer: ____________________
Date of Injury: ____________________
Claim #: ____________________
Adjuster: ____________________
Billing Address: ____________________
City: __________ State: ______ Zip: __________
Phone: __________ Fax: __________

AUTO ACCIDENT (PIP)
Insured: ____________________
Date of Accident: ____________________
Insurance carrier: ____________________
Policy #: ____________________
Claim #: ____________________
Adjustor: ____________________
Billing Address: ____________________
Phone: __________ Fax: __________

ATTORNEY
Name: ____________________
Address: ____________________
City/State/Zip: ____________________
Phone: __________ Fax: __________

AUTO ACCIDENT (3rd Party)
Insured: ____________________
Date of Accident: ____________________
Insurance carrier: ____________________
Policy #: ____________________
Claim #: ____________________
Adjustor: ____________________
Billing Address: ____________________
Phone: __________ Fax: __________

ASSIGNMENT OF BENEFITS

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

RELEASE OF MEDICAL RECORDS

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

FINANCIAL RESPONSIBILITY

It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes partial payment, I am responsible for the balance. A 1.5% interest will acrue monthly on any outstanding balance. If you have contracted with my insurance company at a discount rate and the agreed upon fee has been satisfied, the balance will be waived.

Signature: ______________________________ Date: __________

UMA CLINIC

4425 Fremont Ave N, Seattle, WA 98103

(206) 293-4927

www.umaclinic.com