Minor Patient Information

Today's Date: ______________________

Name: ____ Date of Birth: ______/______/______
(Last) (First) (M.I.)

Billing Address: ____
(Street) (City) (State) (Zip)

Sex: ☐ Male ☐ Female

Primary Physician: __________________________ Referring Physician: _______________________

Parent/Guardian 1 Name: __________________________________ Phone: _______________________

Relationship to Patient: ____________________________________

Parent/Guardian 2 Name: __________________________________ Phone: _______________________

Relationship to Patient: ____________________________________

Guarantor Name: ____

Social Security: ___________ - __________ - __________ DOB: ___________________________

Address: ____

Would you like to be reminded of appointments? ☐ Phone call ☐ email ☐ No Thanks

Patient Email (for appointment reminders): ____

Insurance: Please provide us with your card so that we can make a copy of it. If you are not the insurance subscriber please fill in:

Subscriber: ____________________________________Subscriber DOB: _______________________

Subscriber Social Security: _______-_______-_______

Consent to treatment, promissory note, and authorization to pay medical benefits

1. I, the patient named below, have been informed of the nature and purpose of any treatment and procedures and am aware of the risk and medical complications that may occur. I understand and acknowledge that no guarantee or assurance has been made as to the results that may be obtained. I voluntarily consent to care, treatment, and related procedures.
2. I understand that Pullman Regional Hospital will use and disclose protected health information for the purposes of treatment, payment, and health care operations as authorized by law. If applicable, I have given consent to Pullman Regional Hospital billing staff to discuss the hospital bill with my parents or legal guardian.
3. I promise to pay for hospital services rendered to me. I understand that I may receive bills from Pullman Regional Hospital and related entities for any services performed. Should my account be left unpaid, it will be referred for collection. I shall pay all court costs, reasonable attorney's fees, and collection expenses. It is agreed that Whitman County, Washington has jurisdiction.
4. I understand that among those who attend patients at this hospital are health care personnel in training who, unless requested otherwise, may be present during patient care.
5. Medicare certification/payment: If I am applying for payment under Medicare/Medicaid, I certify that the information given by me is correct. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the organizations furnishing the services or authorize them to submit a claim to Medicare/Medicaid.
6. I understand that repeated failure to attend scheduled appointments without prior notice may result in cancellation of future appointments and discharge from therapy.
7. This consent will expire 90 days from the below date or the end of treatment, whichever is later.

Pullman Regional Hospital does not discriminate on the basis of age, sex, sexual preference, marital status, race, religion, creed, color, national origin, source of payment, or the presence of any sensory, mental, or physical handicap. The patient or authorized representative has read this form and is satisfied that he/she understands its content and significance.
Pullman Regional Hospital keeps a record of the health care services we provide you. You may ask to see and copy that record (copy fees apply). You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Health Information Management. The hospital's Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed and how you can access your information. Pullman Regional Hospital encourages patients to read this policy in full. Changes to this policy will be posted on our website at www.pullmanregional.org. I acknowledge a copy of the hospital's Notice of Privacy Practices has been offered to me.

____
Patient Name

____ _______________
Signature of Patient **Date**

____ _______________ ____________________
Signature of Patient's Guardian/Representative Date Relationship to Patient

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Hospital Representative Signature