THE Portland Clinic

Clinic # _____ **Doctor** _____ **Date** _____

Carrier ID _____ **FC** _____ **Copay** _____

Please Print

Patient Information

Legal Name (First, MI, Last) _____ SS _____

Former/Alternate Name _____ Date of Birth _____ ☐ Male ☐ Female

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Address _____ Apt _____ Primary phone (_____) _____

City/State _____ Zip _____ Work phone (_____) _____

Patient's Relationship to Responsible Party _____ Cell phone (_____) _____

Spouse Name _____ Primary phone (_____) _____

SS _____ Date of Birth _____ Work phone (_____) _____

Responsible Party (Custodial parent if patient is under 18 years old)

Legal Name (First, MI, Last) _____ ☐ MR ☐ MRS ☐ MS ☐ MISS

SS _____ Date of Birth _____

Address _____ Apt _____ Primary phone (_____) _____

City/State _____ Zip _____ Work phone (_____) _____

Employer _____ Occupation _____ Work phone _____

Address _____ City/State _____ Zip _____

***Emergency Contact Name** _____ **Relationship to Patient** _____

Work phone (_____) _____ Primary phone (_____) _____

New to Clinic? ☐ Yes ☐ No Is this an: ☐ Auto Injury ☐ Work Injury ☐ Other

How did you hear about The Portland Clinic?

☐ Family/Friends ☐ Health Plan ☐ Radio ☐ TV ☐ Newspaper ☐ Sports Injury Clinic ☐ Internet ☐ Phone Book
☐ Magazine ☐ MAX/Streetcar ☐ Location ☐ Dr. Referral ☐ Health Fair ☐ Self Referral ☐ Other _____

Would you like to receive our clinic newsletter? ☐ Yes ☐ No Email Address _____

PRIMARY INSURANCE	SECONDARY INSURANCE	PHARMACY INSURANCE
Insurance Name _____	Insurance Name _____	Insurance Name _____
Policyholder _____	Policyholder _____	Policyholder _____
Date of Birth _____ SS _____	Date of Birth _____ SS _____	Date of Birth _____ SS _____
Relationship to Patient _____	Relationship to Patient _____	Relationship to Patient _____
Address _____	Address _____	Address _____
City/St/Zip _____	City/St/Zip _____	City/St/Zip _____
Employer _____	Employer _____	Employer _____
Effective Date of Coverage _____	Effective Date of Coverage _____	Effective Date of Coverage _____
ID Number _____	ID Number _____	ID Number _____
Group Number _____	Group Number _____	Group Number _____
Claims Address _____	Claims Address _____	BIN Number _____
_____	_____	PCN Number _____
Member Services Number (_____) _____	Member Services Number (_____) _____	TIER Number _____
PCP or Referring Doctor _____	PCP or Referring Doctor _____	Member Services Number (_____) _____

HIPAA Notice: Yes/No Staff Initials: Comments:

PLEASE READ THE FOLLOWING CAREFULLY

ALL CLINIC CHARGES ARE DUE AND PAYABLE WITHIN 30 DAYS OF BILLING DATE

The Clinic will automatically bill several major insurance companies. Please verify that your insurance company is one of them. Insurance claims are completed as a courtesy to you, without charge. **The Clinic does not accept the responsibility for collecting your claim or negotiating a settlement on a disputed claim**.

Copays are due at the time of the appointment. If you arrive unprepared to make your copay, you may be charged an additional copayment billing charge of $10.00.

You are responsible directly to the Clinic for payment of your account within the time limit set, regardless of the status of your insurance claim.

If you do not have insurance, you will be required to make a down payment to establish credit with The Portland Clinic. This down payment is not payment in full for services. If your services are greater than or lesser than the down payment we may balance your bill or a refund may be requested. We are unable to quote fees for visits before services are provided.

The Portland Clinic may charge a fee for failed appointments. 24 hour advance notice for cancellations or to reschedule is expected.

*****Balances over 90 days old may be assessed a $5.00 per month rebill charge until the overdue balance is paid in full.****

Any balance sent to Collections will be assessed a fee of thirty-five percent (35%) of the overdue balance.

I authorize the release of any medical information necessary to process my insurance claims. I authorize payment of medical benefits to The Portland Clinic. I understand that I am financially responsible to The Portland Clinic for charges not covered in the assignment.

I understand the above Clinic credit policy and agree to accept responsibility for full payment of my account.

Signature _____ Date _____