Washington Health Medical Group

PATIENT REGISTRATION

Today's Date:_____ Home Phone #_____-_____-_____ Cell Phone #_____-_____-_____

Patient's Last Name:_____ First:_____ Middle Initial:_____

SS #_____-_____-_____ Date of Birth_____/_____/_____ ☐Male or ☐Female *Status*: ☐S ☐M ☐D ☐W

Home Address:_____ Apartment Number:_____

City:_____ State:_____ Zip Code:_____ Email address:_____

Preferred Method of Contact: E-mail ☐Phone ☐Mail ☐

Occupation:_____ Employer Name:_____

Employer Address:_____ City:_____ State:_____ Zip Code:_____

Work Phone #_____-_____-_____ Emergency Contact:_____

Emergency Phone #_____-_____-_____ Relationship to Patient:_____

Referred By:_____ Primary Care Physician:_____

How did you hear about us? ☐Advertisement ☐Employer ☐Friend/Relative ☐Other: _____

Race: Please mark what best describes you. If more than one, please mark numerically in order.

☐White/Caucasian ☐American Indian/Alaska Native ☐Black/African American

☐Asian: _____ ☐Native Hawaiian/Other Pacific Islander

☐Other: _____ ☐Decline

Ethnicity: _____ Hispanic or Latino? Yes ☐No ☐

Which **Language** do you speak in your home?_____

Religion:_____ **Preferred Pharmacy**_____ **Preferred Lab**_____

PRIMARY INSURANCE: Subscriber to Insurance: ☐Self ☐Spouse ☐Parent ☐Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient:_____ SS #_____-_____-_____ Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

SECONDARY INSURANCE: Subscriber to Insurance: ☐Self ☐Spouse ☐Parent ☐Company

Last Name:_____ First:_____ Middle:_____

Relationship to Patient:_____ SS #_____-_____-_____ Date of Birth:_____

Insurance Name:_____ Subscriber ID:_____ Group #_____

WORKERS COMPENSATION: **Did you report the injury to your Employer? ☐Yes ☐No**

Date of Injury: / / _____ _____ Time:_____ AM/PM Claim Number:_____

Where Injury Occurred:_____

Employer Contact:_____ Contact Phone #_____-_____-_____

Worker's Comp Insurance: _____ Policy #:_____Claims Adjuster:_____

Phone: _____ Fax:_____-_____ - _____

Address:_____City:_____ State: Zip Code: _____

Brief explanation of accident and body part injured: _____

_____

_____

(Rev. 1/7/2026)

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CONSENT FOR TREATMENT

I consent to the treatment necessary for the above-named patient ("Patient"). I authorize Washington Hospital Healthcare System ("WHHS") to (i) use and access any or all of the medical records of the Patient, or (ii) disclose and release any or all of the medical records for the Patient to a third party, for the treatment of the Patient or for any purpose described in the WHHS Notice of Privacy Practices available at https://www.mywtmf.com/Patient-Information/Forms.aspx/ ("WHHS NOPP"). I authorize WHHS to obtain the Patient's prescription/medication history electronically from multiple sources, including pharmacies and physicians, as medically necessary for the treatment of the Patient. I authorize and consent that the Patient may (i) receive treatment from a physician, nurse practitioner, or physician assistant, and (ii) an evaluation and examination by a physician or other health professional who may be physically distant from me via telehealth technologies. "WHHS" includes all health care providers subject to the WHHS NOPP, including Washington Hospital, Washington Township Medical Foundation, Washington Outpatient Rehabilitation Center, and Washington Radiation Oncology Center.

INSTRUCTIONS/PATIENT CARE SURVEYS

On behalf of the Patient, I authorize Washington Hospital and all of its employees, independent contractors, business associates, agents, and/or affiliates to contact me or the Patient at any telephone number or email address associated with the Patient's account(s), including wireless telephone numbers (additional charges may apply), for any lawful purpose, including to submit feedback concerning my experience with WHHS, and by any lawful means, including prerecorded or artificial voice messages and/or automated dialing systems or text messages, as applicable.

BEHAVIOR

WHHS has a zero-tolerance standard for workplace violence and is committed to maintain a safe workplace that is free from threats and acts of intimidation and violence for its employees, contractors, agents, and other patients. The Patient and his or her visitors are expected to conduct themselves in a respectful, non-disruptive, non-violent, non-discriminatory, and non-abusive manner.

FINANCIAL RESPONSIBILITY

On behalf of the Patient, I authorize and request that any third party obligated to make payments for the care of the Patient ("insurer") make such payments directly to WHHS. My signature on this form acknowledges that I agree to bear full financial responsibility for all services provided by WHHS that may not be covered by an insurer for the following reasons: (i) not a covered benefit; (ii) not referred or authorized; or (iii) not eligible for coverage with WHHS. I am aware that there is a $25.00 fee for any appointments that the Patient misses without previously contacting the office to cancel. I am aware that I have the right to appeal an insurer's determination of no coverage, but that if my appeal is denied, I will be responsible for the unpaid balance of the bill.

I have been offered a copy of the Washington Hospital Healthcare System Notice of Privacy Practices, a copy of which is also available at https://www.whhs.com/patients-visitors/privacy-practices/. By signing this form, I consent, on behalf of the Patient, to the use and disclosure of the Patient's protected health information for the purpose of treatment, payment, and healthcare operations.

I hereby state that the information I listed above is accurate and complete. I acknowledge that I am responsible for notifying WHHS of any changes made to my contact information and/or insurance.

DATE _____ **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY** _____

PRINTED NAME OF PATIENT OR RESPONSIBLE PARTY _____