NW REST

New Patient Form

365 Warner Milne Rd. Suite 209 | Oregon City, OR 97045
Phone: (503) 495-6200 | Fax: (503) 495-6208

Patient Information	
Name:	Date of Birth:
Address:	
Home Phone:	Cell Phone:
Work Phone:	Email:
Responsible Party / Guarantor	
☐ Same as Patient	
Name:	Date of Birth:
Address:	
Relation:	Home Phone:
Cell Phone:	Email:
Primary Insurance Information	
Primary Insurance	
Insurance Company:	
Member/Subscriber ID:	
Group Number:	

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Secondary Insurance Information	
Secondary Insurance	
Insurance Company:	
Member/Subscriber ID:	
Group Number:	
Emergency Contact	
In addition to being my emergency medical contact, I authorize NW Rest to communicate with the individual listed below regarding medical and/or financial issues.	
Name:	Relation:
Home Phone:	Cell Phone:
Work Phone:	Email:
Assignment of Benefits (AOB)	
I authorize Northwest Rest, LLC dba NW Rest to release any medical records or other information that is necessary to process insurance claims on my behalf. I also authorize payment directly to the provider for services rendered. _____ (initials)	
Financial Responsibility	
I understand that I am financially responsible for any charges not covered by my insurance, including co-pays, coinsurance, deductibles, and non-covered services. I agree to pay any balance in a timely manner and understand that failure to pay may result in collections action. _____ (initials)	

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Consent for Treatment / Services
I authorize Northwest Rest, LLC dba NW Rest to provide diagnostic testing and/or durable medical equipment (DME) services as deemed necessary by my healthcare provider. I acknowledge that I have had the opportunity to ask questions and that I consent voluntarily. _____ (initials)
HIPAA Acknowledgement
I acknowledge that I have received and reviewed the Notice of Privacy Practices for Northwest Rest, LLC dba NW Rest. _____ (initials)
Authorization to Obtain and Release Medical Information
I authorize Northwest Rest, LLC dba NW Rest to obtain and release my medical information as necessary for my care and billing purposes. This authorization is valid for one year from the date signed unless revoked in writing. _____ (initials)
Provider/Hospital to Release Information:
Fax
Information to be Released:

By initialing each statement and signing below, you confirm that you have read, understood and agree to the terms outlined in this document.

_____ _____

Patient / Guardian Signature Date