

SHEREEN MORSE, M.D.

PSYCHIATRY

2208 NW Market Street, Ste 503, Seattle WA 98107
T (206) 353-1150 F (206) 632-2248

NEW PATIENT REGISTRATION

GENERAL INFORMATION

Name: _____ DOB: _____ Sex: _____

Mailing Address: _____

City, State, Zip: _____

SSN: _____ Employer: _____

Home Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

Cellular Phone: _____ May we leave a message? Yes No

MEDICAL AND REFERRAL INFORMATION

Name of Primary Care Provider: _____

Telephone Number: _____

Who referred you to this practice? _____

EMERGENCY CONTACT

Who should we contact in case of an emergency? _____

Relationship to you: _____

Home Phone: _____

Cellular Phone: _____

Other: _____

I understand that having an appointment scheduled does not guarantee that a treatment relationship has been established between Dr. Morse and myself. Similarly, keeping that scheduled appointment does not mean that Dr. Morse has agreed to be my doctor or that I have agreed to be her patient.

An initial appointment is a consultation and it is an opportunity for both Dr. Morse and myself to evaluate if a treatment relationship should be started. Only when Dr. Morse and I both agree to it, will we formally be in a treatment agreement.

Initial here _____

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HEALTH INSURANCE INFORMATION

In order for any claims to be submitted to your health insurance company the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

City, State, ZIP: _____

Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Patient ID: _____ Patient Birth Date: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME A CONTRACT IS ISSUED OR THE EMPLOYEE COVERED UNDER AN EMPLOYER'S GROUP HEALTH CONTRACT.*

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____

Insurance Company Telephone: _____

Insurance Company Address: _____

City, State, ZIP: _____

Patient's Relationship to Subscriber: Self Spouse Child Other: _____

Patient ID: _____ Patient Birth Date: _____

*Subscriber on Policy: _____

Subscriber ID: _____ Subscriber Birth Date: _____

Subscriber Insurance Group #: _____ Subscriber SSN: _____

Subscriber Address: _____

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that Shereen Morse, M.D. reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that Dr. Morse and support staff have already taken action in reliance thereon. I also understand that Dr. Morse and her support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize Shereen Morse, M.D. to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.*

**The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.*

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

ASSIGNMENT OF BENEFITS

I hereby assign to Shereen Morse, M.D. my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid, in my name or on my behalf. I further authorize payment of benefits directly to Shereen Morse, M.D. I understand that I am responsible for satisfying the precertification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by Shereen Morse, M.D.. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____