



Lower Elwha Health Department

MRN:

243511 Highway 101 West,

Port Angeles, WA 98363

Phone: 360.452.6252 Fax: 360.452.6274

PAO 21 Form

Today's Date:	Who is your PCP:
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PATIENT INFORMATION

Patient's last name:		First:	Middle:	Marital Status:	
Preferred name:			Pronoun:		
Is this your legal name? [] yes [] no	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
Mailing Address:					
City:		State:	Zip:		
Physical Address: [] (Check box if same as above)					
City:		State:	Zip:		
Social Security no.:	Primary phone no.:		Secondary phone no.:		
Occupation:	Employer:		Employer phone no:		
Do you have internet access? [] yes [] no	Email address:		Preferred method of communication? [] PHONE [] MAIL [] DO NOT CONTACT		

AMERICAN INDIAN / ALASKA NATIVE INFORMATION

Religious Preference:	Tribe of Membership:	Tribal Enrollment Number:
Tribal Blood Quantum:	Other Tribe and Blood Quantum:	Which parent is descendency through: [] Mother [] Father

IN CASE OF EMERGENCY

Emergency contact:	DOB:
Relationship to patient:	Home phone no:
Name of relative (Next of Kin):	
Relationship to patient:	Home Phone no:

BILLING INFORMATION

(Please give insurance card to the receptionist)					
Check here if person responsible for bill is patient [] Please proceed to INSURANCE INFORMATION on page 2					
Person responsible for bill (if different from patient):					
Birth date:	Address:			Home phone:	
Is this person a patient here: [] yes [] no			Is this patient covered by insurance: [] yes [] no		
Occupation:	Employer:	Employer address:	Employer phone no.:		



ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I hereby authorize direct payment of medical benefit to the provider of services at the Lower Elwha Health Clinic. If I do NOT qualify for Indian Health Services benefits; I understand that I am financially responsible for any balance not covered.

I certify that even if I am eligible for Indian Health benefits that I have disclosed all other insurance eligibility in this application. I also verify that all information provided is accurate according to my knowledge at this time.

I hereby authorize the provider to release all information necessary to secure payment of insurance.

I understand that this release will be valid for one year from the date signed or unless there is a change in insurance coverage when I must sign and date a new APB/ROI.

CONSENT TO TREAT

I have voluntarily presented myself at the Lower Elwha Health Department. Unless I specifically indicate otherwise, I give consent to evaluate, examination, testing and treatment recommended by the healthcare professionals and other appropriately authorized professional staff members under the Lower Elwha Health Department.

I understand that to provide appropriate care, my provider will share copies of my pertinent records with consulting provider who I am referred to.

I have read and understand Lower Elwha Health Department Patient Rights and Responsibilities. I will honor these responsibilities and require that I be granted these rights by the staff of the Lower Elwha health Department.

I understand this consent for medical care shall hold valid for all future visits unless I specifically discuss otherwise with my Provider at the time of a treatment is proposed or prescribed.

Patient/Guardian Signature

Date

Printed Name