yakimaworkercare.com

PATIENT REGISTRATION

Yakima Worker Care
409 S 12th Ave
Yakima WA 98902
Phone 509-575-2949
Fax 509-575-5743

Sunnyside Worker Care
1614 E Edison, Suite E
Sunnyside WA 98944
Phone 509-836-0075
Fax 509-836-0077

Pasco Worker Care
1500 W Court St
Pasco WA 99301
Phone 509-543-7717
Fax 509-543-7721

Name ____

Date of Birth ______________________________________

Work Phone _______________________________________

Email ____

Cell Phone ____

Cell Provider (if prefer text message reminders) _________________

Reminder Preference(s): ❑ Text ❑ Email ❑ Phone

Please complete if <u>NOT</u> filling out Report of Accident or Reopening Application today.

Claim # ______________________________

Soc Sec # ____________________________

Address ____

City ____________________ State _____ Zip _____________

Employer of Injury__________________________________

Occupation ___________________________

Home Phone ____________________________________

❑ Married ❑ Single ❑ Separated

❑ Divorced ❑ Widowed ❑ Domestic Partner

Name of Husband/Wife/Partner _______________________

In Case of Emergency Contact

Name ______________________________________ Relationship _________________ Phone ________________

Local Personal Physician ____

How Did You Hear About Us?____

Please read before signing:
I understand that I am financially responsible for all charges including, but not limited to, deductibles and services not covered by my insurance, regardless of coverage, and I agree to pay such charges. My signature below permits the release of all information necessary to secure payment of benefits from my insurance carrier. I understand that all laboratory, x-ray, and other testing performed by outside facilities and specialists will be billed directly to the patient by these facilities and specialists.

AUTHORIZATION: I hereby authorize the Doctor(s) and the medical staff of Yakima Care Worker to provide such medical services as may be determined to be in the best interest of the patient listed above.

I hereby authorize any holder of medical information about me to release any information needed to process my claim. I also authorize any insurance benefits to be made to Yakima Worker Care.

Our Notice Of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. By my signature below, I acknowledge receipt of the Notice Of Privacy Practices.

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Signature of Patient or Legally Auth.

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Date