Oregon Specialty Group

Registration Form

Patient Information

Patient's Name (Last, First, MI)		**Age:**	**Ethnicity:**
Date of Birth (mm/dd/yyyy)	**Gender** ☐ Male ☐ Female ☐ Non-Binary	**Marital Status** ☐ Single ☐ Married ☐ Widowed ☐ Divorced	**Language spoken:**
Street Address		City State	Zip
Mailing Address (if different from Street Address)		City State	Zip
Phone # (preferred)	Alternate Phone #	**Email Address**	Social Security #
Person to contact in case of emergency **and** relationship to patient			Emergency Contact Phone #
Referring Physician	Primary Care Provider	Currently enrolled in hospice? ☐ Yes ☐ No	Do you live in a skilled nursing facility? ☐ Yes ☐ No If yes, where? ______________________
Employer		Work Phone #	Occupation
Person financially responsible for this account: ☐ Self ☐ Spouse ☐ Parent		Responsible party's Date of Birth (if other than patient)	Responsible party's Social Security # (if other than patient)

Insurance Information

Primary Insurance Company	Address		Is insurance through your employer? ☐ Yes ☐ No
Subscriber Name	Subscriber Date Birth	Policy #	Group #
Secondary Insurance Company	Address		
Subscriber Name	Subscriber Date Birth	Policy #	Group #

Authorization to Release Medical Information & Assignment of Benefits (the "*Authorization & Assignment*")

I, the undersigned patient or legal guardian, understand that the cost of services rendered to me by OSG* are my financial responsibility, including any balance not paid by my insurance carrier. I hereby authorize and request OSG to bill and collect payment for medical services rendered from the insurance company(ies) listed above and/or other third-party payers, such as Medicare and other government sponsored programs. I understand and agree to the following terms:

1. I authorize my insurance carrier to release information regarding my coverage to OSG, and I authorize OSG to release any information necessary to process claims for payment. I understand and authorize that my health information may be used and disclosed by OSG, other providers, and insurers for treatment, payment, and health care operations purposes. I have received, read, and understood OSG's Notice of Privacy Practices.
2. I hereby assign to OSG all rights to payment for all benefits, including but not limited to, pharmaceuticals, procedures, tests, medical equipment rentals, supplies, nursing/provider services and all major medical benefits, to which I am entitled. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans and I authorize any and all payments to be paid directly to OSG. I acknowledge this is a legally binding assignment. In the event my insurance carrier does not accept this assignment, and/or if payments are made directly to me or my representative, I will endorse such payments to OSG.

***OSG includes Oregon Specialty Group, Oregon Oncology Specialists LLP, Oregon Rheumatology Specialists, Oregon Infectious Disease Specialists and Oregon Specialty Infusion, as well as their affiliates, and including all healthcare providers within the practice.**

I understand that this Authorization & Assignment will remain in effect unless revoked by me in writing to OSG. If revoked, I understand the information described in Section 1 above may no longer be used or disclosed for the purposes described therein, except for when a covered entity has taken action in reliance on this authorization or this authorization was obtained as a condition of obtaining insurance coverage.

Signature of Patient or Legal Representative of Patient: ____ Date: ____________________________

Printed Name of Patient or Legal Representative of Patient: ____

Description of Representative's Authority (if applicable): ____