TODAY'S DATE	SOUND CLINICAL MEDICINE, PS MICHAEL WINGREN, MD	MVA or PI FORM	PATIENT ID #

PATIENT: Please complete as much of the information on this form as possible.

FIRST NAME	MIDDLE OR INITIAL	LAST NAME			E-MAIL:
ADDRESS		CITY	STATE	ZIP	HOME PHONE #
DATE OF BIRTH	SEX ☐ M ☐ F	PATIENT'S SOCIAL SECURITY #			CELL PHONE #
EMPLOYER					BUSINESS PHONE #
REFERRED BY:		NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY			EMERGENCY CONTACT PHONE #

ATTORNEY:

FIRST NAME	INITIAL	LAST NAME			
ATTORNEY ADDRESS		CITY	STATE	ZIP	ATTORNEY PHONE #

ACCIDENT AND INSURANCE INFORMATION:

DATE OF INJURY:	PLACE OF INJURY:

☐ DRIVER OF MY CAR ☐ DRIVER OF ANOTHER CAR ☐ PASSENGER IN MY CAR ☐ PASSENGER IN ANOTHER CAR ☐ PEDESTRIAN

PATIENT'S AUTO INSURANCE COMPANY	CLAIM #	POLICY #

INSURED'S NAME	PATIENT'S RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ARE YOU COVERED UNDER PERSONAL INJURY PROTECTION? ☐ YES ☐ NO

INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP	INSURANCE CO. PHONE #

DO YOU HAVE OTHER MEDICAL INSURANCE COVERAGE? ☐ YES ☐ NO PERSONAL ☐ THIRD PARTY ☐

PERSONAL MEDICAL INSURANCE COMPANY	INSURED'S ID #	INSURED'S NAME
THIRD PARTY MEDICAL INSURANCE COMPANY	INSURED'S ID #	INSURED'S NAME

HIPAA: ACKNOWLEDGEMENT OF RECEIPT/OFFER OF NOTICE OF PRIVACY PRACTICES; RELEASE OF INFORMATION

Federal law requires us to provide you with a Notice of Privacy Practices, our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice. You have the right to review our notice before signing this acknowledgement, and if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclosure of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us, and also send you a revised copy upon your request. Your signature on this form acknowledges that you have received, or have been offered and refused, a copy of our Notice. In addition, by signing this agreement, I authorize Sound Clinical Medicine, PS and Dr. Michael Wingren to release any information needed to process my insurance claims, in accordance with HIPAA privacy regulations.

SIGNED: DATE:

ASSIGNMENT AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

I hereby authorize my insurance Benefits, including Personal Injury Protection (PIP) benefits, to be paid directly to Sound Clinical Medicine, PS. If PIP is not available, exhausts or terminates, I give permission to bill my private medical insurance for those services rendered. I authorize Sound Clinical Medicine, PS and Dr. Michael Wingren to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010 et seq. I authorize my attorney to pay in Full any outstanding balance owed to Sound Clinical Medicine, PS at the time of settlement of my claim. I understand that I will receive a written Satisfaction of Lien and that I am responsible for filing with the County and for paying the cost of the filing fee for any such Satisfaction of Lien. I understand that if my insurance benefits, PIP, and/or the payment of any medical lien does not fully pay my outstanding final charges due to Sound Clinical Medicine, PS, I am personally financially responsible for, and will pay the balance due. I understand that a monthly rebilling charge of 1% (or a $10.00 minimum monthly charge) will be applied to any unpaid account balance over 30 days past due.

SIGNED: DATE:

ADDITIONAL AGREEMENT: 1. If Sound Clinical Medicine, PS is asked to bill the patient's private medical insurance for accident-related charges, it is the responsibility of the patient and their attorney to promptly contact the patient's insurance company directly to file "Subrogation." 2. All amounts that are due from the patient for co-pays, co-insurance, and deductibles, as established by the applicable private insurance policy, must be paid at the time the service is provided—these balances cannot be held until settlement. 3. If the patient is not covered by auto accident insurance or private medical insurance, they must be represented by an attorney, and the attorney must promptly provide a Letter of Protection to Sound Clinical Medicine, PS. A Letter of Protection is a letter that states that the attorney's office will pay the balance in Full at settlement. Sound Clinical Medicine, PS will not discount the balance due, because its fees are reasonable. If the patient's attorney does not pay the balance in full, the patient will be held personally responsible for any remaining balance. The patient's signature on this form indicates that they understand and agree to this policy.

 SIGNED: DATE: