SNORING & SLEEP APNEA CENTER
Katharine Christian DMD
2101 4th Avenue • Suite 2330 • Seattle, WA 98121
(206) 770-0260 / (206) 770-0182 fax
Practice Limited to Snoring, Sleep Apnea, & TMD
American Academy of Dental Sleep Medicine • American Academy of Sleep Medicine•National Sleep Foundation
www.sleep911.com

NEW PATIENT REGISTRATION

Date _____

First Name _____ Middle Initial_____ Last Name_____

Street_____City_____ State____Zip_____

Phone: Home_____ Work_____ Cell_____

Date of Birth____/____/_____ SSN_____ Employer_____

Insurance Co. _____Insurance ID No. _____Group No._____

2nd Insurance _____Insurance ID No. _____ Group No._____

Referral Required? Yes☐ No ☐ If 'yes', please contact your Primary Care Provider for referral

PCP (Primary Care Physician) _____Tel. No. _____ Last exam_____

Emergency contact: _____ Tel. No. _____

Referred to Dr. Christian by_____

OFFICE POLICY:

Your appointment is time set aside exclusively for you, so please remember, we require at least a 48 hour notice of cancellation or changes. Repeated cancellations/no shows will trigger an escalating cancellation fee. Accounts are due and payable at time of service regardless of insurance coverage. If you have insurance coverage and desire extended payment, such arrangements must be made before services are provided. A very small percentage of Insurance Companies may not cover our specialized Diagnostic Testing. Please be advised, any non-covered procedures are considered patient expense.

✶RELEASE OF INFORMATION & INSURANCE AUTHORIZATION:

I hereby authorize Dr. Christian to release any information necessary to process my claim. I authorize payment of medical benefits to be paid to Dr. Katharine Christian for services rendered.
Date _____Signature_____

FINANCIAL RESPONSIBILITY AGREEMENT:

You are fully responsible to pay your account as agreed, regardless of the status of any pending insurance claim you may have. We cannot be responsible for collecting insurance claims, negotiating settlement or disputed third party claims. You will receive a monthly statement until your account is paid in full. All accounts over 90 days past due will be charged a service charge of 1%, with a minimum of $1.00 charge per month. Should your account be referred for collection, you will pay all reasonable collection fees.
We are a Preferred Provider with AETNA, United HealthCare, and First Choice – We are Out of Network with other insurances (i.e Premera Blue Cross). However, we will endeavor to obtain the highest benefit reimbursement possible for you and file all Medical claims.

Date_____ Signature _____ Printed Name _____