

Client Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Other names that records may be kept under: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_
SS#: \_\_\_\_\_ Home Ph:(\_\_\_\_\_) \_\_\_\_\_ Work Ph:(\_\_\_\_\_) \_\_\_\_\_ Cell
Ph:(\_\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_
May we leave confidential voice-mail messages for you at any of the above numbers? No Yes (specify): Home/Work /Cell
Are you currently employed? Y N
Employer: \_\_\_\_\_
Mother's Name (minors only): \_\_\_\_\_ Father's Name (minors only): \_\_\_\_\_
Emergency Contact: \_\_\_\_\_ Contact's Phone #: (\_\_\_\_\_) \_\_\_\_\_
Relationship to Emergency Contact: \_\_\_\_\_ Do you have special needs? \_\_\_\_\_

The following information is requested for demographic identification and is never distributed or sold:

Marital Status (circle one): Single/Never Married Married Divorced Separated/Not Divorced Widowed
Domestic Partnership Race/Ethnic Origin: African/African-American Asian Caucasian Native American Pacific
Islander/ Native Hawaiian Mixed Race Other How did you hear about us? Google (keyword \_\_\_\_\_)
Superpages Other \_\_\_\_\_ Friend/Family member \_\_\_\_\_
Number of members in your household: \_\_\_\_\_ Gross annual household income: \_\_\_\_\_ /year

Guarantor Information

This must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_
Middle Initial: \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone:
(\_\_\_\_\_) \_\_\_\_\_

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X \_\_\_\_\_
Guarantor's Signature Date

Payment is expected at the time services are rendered unless prior arrangements have been made.

Payments can be made by Visa, Mastercard, Discover, check, and cash. We are a preferred provider for Regence (WA), Premera (WA), Uniform, Cigna, Aetna and First Choice Health Network. Coverage as an out-of-network provider may be partially reimbursable, but is NOT guaranteed, and payment is required at the time of service on all non-preferred provider plans.

It is the client's responsibility to confirm individual coverage with their insurance company prior to the visit. (INITIAL)

A \$100 late-cancellation fee will be incurred with less than 24 hours notice and a \$150.00 No-Show fee if no notice given.

Personal emergencies will be given reasonable courtesy consideration. I understand these are not covered by insurance.

(INITIAL)

Terms of Admission

Financial terms: I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that payment for non-preferred provider services is due at the time of service and a claim will be submitted on my behalf though reimbursement is not guaranteed. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is authorized to receive my medical information unless expressly authorized by me in writing. A fee may be assigned in the case of no-shows or late cancellations (less than 24 hours). Extenuating circumstances will be considered at the discretion of the physician

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so.

We are required to provide you with a copy of our Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describe your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call us at 425.744.1679.

I hereby acknowledge that I have received a copy of Seattle Naturopathic Clinic's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that SNC has made a good faith effort to obtain my acknowledgement.

X \_\_\_\_\_
Patient's Signature Date

X \_\_\_\_\_
Representative's Signature / Relationship/Authority Date