Seattle Naturopathic Clinic 7500 212th St SW Ste 107 Edmonds, WA 98026
(425) 361-1245

Client Information

Last Name: _____First Name: _____Middle: _____
Date of Birth: _____ Sex:_____ Other names that records may be kept under: _____
Address: _____ City: _____ State: _____ Zip Code: _____
SS#(last 4 only)_____ Cell :(_____)_____ Home:(_____)_____Work:(____) _____
Email:_____

May we leave **confidential** voice-mail messages for you at any of the above numbers? No Yes (specify): **Cell**/**Home**/**Work**
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:
How did you hear about us? Google (keyword_____) Other_____ Friend/Family member_____
Marital Status (circle one): Single Married Domestic Partnership Divorced Separated Widowed
Race/Ethnic Origin: African-American Asian Caucasian Hispanic Native American Pacific Islander Other _____
Number of members in your household: _____ Gross annual household income: _____ /year

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Payment is expected at the time services are rendered unless prior arrangements have been made. Payments can be made by Visa, Mastercard, Discover, or check. We are a preferred provider for Regence, Premera, BCBS, 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 $25 late-cancellation fee will be incurred with less than 24 hours notice for any reason and a **$100.00 No-Show fee if no notice given. I understand these are not covered by insurance._____(INITIAL)**

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 Last 4 of SSN# Date

Financial policy: I understand that if I am providing insurance billing information, I am responsible for all charges whether or not they are covered by my insurance. 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. 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 policy: 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 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 otherwise.

By providing my signature below, I hereby agree to all stated policies and grant permission to receive professional services rendered by Seattle Naturopathic Clinic. I authorize the release of any medical information in order to process insurance claims for payment.

X _____ _____
Patient's Signature Date

X _____ _____
Guardian/Representative's Name/Relationship Signature Date