BELLINGHAM
NATURAL FAMILY MEDICINE

## PATIENT INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____ City/State _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

SS#: _____ Emergency Contact: _____

**BILLING: ___ CASH ___ AUTO ___ HEALTH INS.** Referred By: _____

Your Insurance Co. _____ Address: _____

Policy No. _____ Claim No. _____ Contact Person: _____

Subscriber Name: _____ Family Physician: _____

Secondary Insurance?(Please ID) _____

Date of Injury: ____/____/____ City/State of Injury: _____ Attorney: _____

*Chief Complaint / Reason for Visit:* _____

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## ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY and NOTICE OF INFORMATION PRACTICES

By signing below I authorize all insurance payments to be made directly to this Provider, and I also understand that my signature allows the release of my medical record to my health insurance company as necessary. Any other release (including to PIP/3rd Party Payors) of medical or billing information will require an additional valid written authorization by me as required by RCW 70.02.030. I understand a reasonable fee will be assessed for such copies as authorized by WAC 246-08-400 and charged to the requesting party. I further understand that I may inspect/copy/request correction of my medical record in accordance with RCW 70.02.120 by submitting a written request and authorization to this health care provider.

I understand that my primary insurance company will be billed directly on my behalf for treatment rendered. I agree to take full responsibility for *any and all* remaining balance not paid by my insurance company including: co-pays, deductibles, non-covered services, etc.; services denied due to lack of referral, non-participating provider, etc.; and, in the case of an auto accident claim, *any and all* unpaid bills by any insurance company or attorney for any reason at the close of the claim. Any balance over 90 days old may be assessed interest at the rate of 12% per annum.

I understand my insurance will not cover missed appointments, therefore payment for cancellations without 24 hours notice or missed appointments are my responsibility.

Signature: _____ Date: _____