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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____Patient Name _____
SSN _____ Gender: Male Female Birthdate _____ Home phone _____
Address _____ Cell phone _____
City _____ State _____ Zip _____ Email _____
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's or parent's employer _____ Work phone _____
Business address _____ City _____ State _____ Zip _____
Spouse or parent's name _____ Employer _____Work phone _____
If patient is a student, name of school/college _____ City _____ State _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence:
Signature _____ Date _____

Responsible Party/Primary Insurance Holder:
Name of person responsible for this account _____ Relationship to patient _____
Address _____ Home phone _____
Driver's license # _____ Birthdate _____
Employer _____ Work phone _____
Is this person currently a patient at our office? ☐ Yes ☐ No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization at any time to obtain a current copy of the Notice of Privacy Practices. I also understand that if I have any questions or complaints, I may contact the organization. I have the right to revoke this authorization in writing except to the extent that Natural Family Medicine of Cascade Park, PC, has acted in reliance upon this authorization. My written revocation must be submitted to Natural Family Medicine of Cascade Park, PC, 16701 SE McGillivray Blvd., Suite 265, Vancouver, WA 98683.

CONSENT FOR MEDICAL TREATMENT

I am requesting and hereby authorize services offered to me by Natural Family Medicine of Cascade Park, PC, including physical examination, any tests and/or treatment deemed appropriate by my provider. As a patient, I am to be fully informed of benefits and possible complications, as well as alternatives to the proposed treatment, including no treatment. I understand that I am responsible for all fees regardless of insurance coverage and/or treatment outcome.

I confirm that I have read and fully understand all of the above prior to my signing. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Patient Name (please print) _____Date: _____
Signature of Patient (parent or guardian if patient is a minor) _____