Northwest Pediatric Center

(18 year +) It is very important that we have your Patient Information correct – PLEASE PRINT CLEARLY

Patient Number: _____ Birthdate: _____/_____/_____ Sex: _____ Social Security Number: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone: _____ Email: _____

Employer: _____ Occupation: _____

Primary Language: ____ English ____ Spanish Other (list) _____ Ethnicity: _____ Not Hispanic _____ Hispanic ____Unknown

Race (check all that apply: _____ White _____ Native American _____ Black _____Asian _____ Pacific Islander **School**: _____

How would you like appointment reminders? Email _____ Text to Cell _____ Phone call _____

Would you like secure access to your medical record through our Patient Portal? Yes_____ No_____

IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU WILL BE CONSIDERED SELF PAY

Are you covered by Apple Health or Provider One? _____ Yes _____ No

Primary Insurance:

Subscribers Name: _____ Sex: ___M ___ F Subscribers DOB: _____/_____/_____

Relationship to Patient: _____

Name of Insurance Company: _____

Employer (Group) Name: _____

Subscribers ID# _____ Group #: _____

Secondary Insurance:

Subscribers Name: _____ Sex: ___M ___ F Subscribers DOB: _____/_____/_____

Relationship to Patient: _____

Name of Insurance Company: _____

Employer (Group) Name: _____

Subscribers ID# _____ Group #: _____

Emergency Contact: _____ Relationship to Patient _____ Phone: _____

HIPAA Privacy Practices: I acknowledge that Physician's Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician/provider has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me.

Signature: _____ **Date** _____

I understand that I am financially responsible for all charges, regardless of insurance coverage. Payment is required at the time of service unless other arrangements have been made in advance with the billing department. All insurance claims are your responsibility. Copays and deductibles must be paid at the time of service. If it becomes necessary to assign collection of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I have read the above policy. I hereby assign to the physician/provider all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance plan.

Signature: _____ **Date:** _____

Print Name: _____

Preferred Pharmacy: _____ **Location:** _____

Verbal Communication To:

_____
(Name)

_____
(Address)

_____
(Phone Number)

_____
(Relationship to Patient)

Release From:

Northwest Pediatric Center and Providers

1911 Cooks Hill Rd.

Centralia, WA 98531

I, _____ hereby grant

Northwest Pediatric Center and Providers

Permission to verbally discuss to the above designated person the items checked below:

__ Communication necessary to coordinate ongoing care
__ Drug or Alcohol history
__ HIV
__ Immunization record
__ Laboratory reports
__ Medications
__ Psychiatric disorders/mental health
__ Reproductive Care
__ Sexually transmitted diseases
__ Summary of medical history
__ Account Balance(s)
__ Insurance questions/concerns

__ Other: _____

I understand that this consent allows verbal communication of the designated records for the following period:

__ 12 months from today's date

I also understand I may revoke this consent in writing at any time, but that such revocation becomes effective only when received by

Northwest Pediatric Center and Providers

and that disclosure made before such revocation is received is not affected.

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clinical and administrative staff maintains patient confidentiality in strict compliance with state and federal laws. These practices are supported by policies and procedures. These procedures are reviewed and, if necessary, revised on a regular basis. We will ensure that HIPAA regulations on re-disclosure are followed. However, after the information leaves this clinic, we cannot guarantee privacy protection of your health information.

Signature: _____Date signed: _____
(Patient/Requestor)

Printed name: ______________________________________ Witness: ______________________