PATIENT'S NAME _____ GENDER _____ DATE OF BIRTH _____

PATIENT LIVES WITH _____

SIBLING'S NAME(S) _____

FATHER: HOME PHONE:

ADDRESS: CELL PHONE:

CITY/ZIP: DATE OF BIRTH:

E-MAIL:

MOTHER: HOME PHONE:

ADDRESS: CELL PHONE:

CITY/ZIP: DATE OF BIRTH:

E-MAIL:

FATHER'S EMPLOYER: WORK PHONE:

MOTHER'S EMPLOYER: WORK PHONE:

Emergency Contact: _____ **Phone:** _____

Preferred Pharmacy: _____ **Phone:** _____

PRIMARY: Insurance Company_____ Effective Date_____ Copay_____

Insured Parent's Name _____ ID#_____

Group #_____ Claims Address_____

SECONDARY: Insurance Company_____ Effective Date_____ Copay_____

Insured Parent's Name _____ ID#_____

Group #_____ Claims Address_____

****By my signature below I acknowledge that I have received the WPHC Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can access my information.**

****I am <u>NOT</u> receiving state Medicaid, (DSHS, Medical Coupons) at this time, I will inform your office before being seen if I receive medical coupons in the future.**

****A no-show fee of $25 will be added to any no show appointment and/or appointments that are not canceled more than 24 hours of the appointment time.**

Please note: In order to control the costs of billing we request that office visits be paid at the time of service unless appropriate insurance information is provided. A finance charge of 1.0% will be added to your account on a monthly basis if your balance is 60 days or older. A minimum finance charge will be $.50 per month on any account older than 60 days. Total annual finance percentage will equal 12% on any account balance that is older than 60 days. (RCW 19.52)

I hereby certify that all of the above information is true. I agree to have medical information released for billing purposes to my insurance carrier and to billing personnel. I agree to pay for any charges not payable by my insurance plan. I furthermore, have read the above and understand that I am responsible for all medical and financial charges.

Signed: _____ **Date:** _____