GREENLAKE PRIMARY CARE PEDIATRIC PATIENT INFORMATION

Patient's Name_____
First Initial Last

Gender: M F Social Security No_____-____-_____(if known) Birth Date_____
(Mo./Day/Yr)

Who lives in the house with the child _____

Street Address where patient lives_____
Street/P.O.Box (Apt #) City State Zip

Primary Phone Contact # (____)_____ Referred by_____
circle: home work cell pager other

PARENT/GUARDIAN #1 INFORMATION

Relationship to patient_____

Name_____ Birth Date_____ Occupation_____

Home Address (if different from above)_____

Home Phone # (____)_____Other # (____)_____
cell pager message other

Work Phone (_____)_____ Employer:_____

Primary Language spoken _____ Mother's Maiden Name_____
(if non- English)

Social Security No. _____-____-_____ Insurance provided by this person? _____
(Please provide insurance card to receptionist)

PARENT/GUARDIAN #2 INFORMATION

Relationship to patient_____

Name_____ Birth date_____ Occupation_____

Home Address (if different from above)_____

Home Phone (if different from above) (____)_____Other # (_____)_____
cell pager message other

Work Phone (_____)_____Employer:_____

Primary Language spoken _____ Mother's Maiden Name_____
(if non-English)

Social Security No. _____-____-_____ Insurance provided by this person?_____
(Please provide insurance card to receptionist)

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____
Relationship to patient

Address_____
City State Zip

Home Phone # (____)_____Work # (____)_____Other # (____)_____
(cell, pager, message)

FAMILY INFORMATION

Sibling names and birth dates: _____

_____

INSURANCE INFORMATION

Whose insurance plan is primary? (Parent#1 or Parent#2)_____

Any secondary/tertiary insurance not shown above?_____

Person responsible for bill_____Address_____
(if different from above)

If the billing statement should be sent to any address other than the patient's, please fill it in here and include the relationship of the individual to whom it is to be sent._____

_____

Photo copies of insurance cards go here

Consent for Care of a Minor: I, _____ give permission
(Parent or Guardian)

authorize the providers and staff of Greenlake Primary Care to examine and treat

_____ .
(Patient) (Date of birth)

Insurance Release of Benefits and Information: I authorize insurance benefits for my child to be paid directly to the provider or clinic. I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my child's insurance plan. I authorize the physician/nurse practitioner or insurance company to release any information required for processing of insurance claims. This authorization is in effect until rescinded in writing.

Date: _____ Signature: _____

Greenlake Primary Care Financial Policy

Greenlake Primary Care participates with a wide variety of insurance plans including: Aetna, Cigna, First Choice, Labor & Industry, Medicare, Molina (**for children only**), Premera, Regence, Tri Care, Uniform, United Healthcare, and others.

Know your insurance plan. Before your visit, or if you change insurance companies, call the toll free number on the back of your insurance card.
Ask your insurance representative if the practitioner you wish to see is a provider covered on your plan. Then please designate us as your primary provider, if necessary.
You may also ask whether you need a written referral to specialists, how often this needs to be renewed, and your coverage and benefit limits.
Then:

- Bring your insurance cards to every visit.
- Tell us if your insurance has changed.
- Pay your co-pay at the time of your visit.

Greenlake Primary Care will submit your bill to your insurance company for you.

If you do not have medical insurance, it is your responsibility to make full payment at the time of your visit for the services given. If there is financial hardship, please tell us.

Please note:

- For your convenience we accept both Visa and Master Card.
- Checks returned for insufficient funds will result in an immediate charge of $35.00 against your account.
- There may be a minimum charge of $50.00 for not canceling your appointment 24 hours in advance.
- If payment at the time of service is a hardship, a special payment plan can be arranged. These plans generally do not span more then three months.
- Questions about your account can be answered by Jonathan at our billing office (206-528-2663).

Financial Responsibility, Release of Insurance Benefits, Release of Health Information to Insurer:
I authorize Greenlake Primary Care to request and directly collect, on my behalf, all public and private insurance coverage benefits due for products and services provided by Greenlake Primary Care.
I authorize Greenlake Primary Care, to release any health care information necessary to facilitate the processing of claims and audit of payments, for the services provided to me or my child by Greenlake Primary Care. The authorization is in effect until rescinded in writing.
If insurance benefits are paid directly to me, I will endorse these checks for such payments to Greenlake Primary Care.
I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my insurance plan.

I have read and understand this policy. A copy will be kept in my chart and a copy may be furnished to me at my request.

Print patient name _____ Date of Birth_____

Signed: _____ Date:_____

(Last update 11/1/2012)

Greenlake Primary Care

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. We will not disclose your record to others unless you direct us to do so, unless the law authorizes or compels us to do so, or for the coordination of your care with another healthcare provider.

You may see your record and/or get information about it by contacting your practitioner.

You may ask for a copy of the record. There may be a record-copying charge, unless you are asking that records be sent to another practitioner. You may also ask to correct your record.

Our Notice of Privacy Practices describes in more detail how your health care record may be used and disclosed, and how you can access your information. Copies are available at our office or on our website: www.greenlakeprimarycare.com.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices. This signed acknowledgement form of my review will be retained in my medical record, in accordance with HIPAA Privacy Act regulations.

Patient Name_____ Date of Birth_____

_____

Signature of Patient/Guardian/ Legal Surrogate for Health care Date

_____ Printed

name of signer Relationship (parent, legal guardian, personal representative)

Pediatric Patients only: I hereby give my permission to Greenlake Primary Care to display on their bulletin board any pictures of my children that I supply to the clinic. Yes No

Signature_____ Date_____

(Parent, legal guardian, personal representative)

(Last update 7/1/2011)