Patient Information Form

Last Name _____ First Name _____ Middle Name _____

Date of Birth (Required) ____/_____/_____ Gender _____ Other names that records may be kept under _____

Address _____ City _____ State _____ Zip _____

SS# _____ Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

May we leave confidential voice-mail messages for you at any of the above numbers? ❍ No ❍ Yes (specify) **❍ Home ❍ Work ❍ Cell**

Are you currently employed? ❍ Yes ❍ No Employer _____

Are you a Bastyr employee, student, or significant other of a student or staff member? ❍ No ❍ Yes (specify) _____

Emergency Contact Name _____ Phone # (_____) _____Relationship _____

How did you hear about us? ❍ Medical Referral ❍ Printed Ad ❍ News Story ❍ Mailer/Flyer ❍ Google/Internet Search ❍ Workshop/Event ❍ Friend/Family ❍ Bastyr Employee or Student ❍ Yellow Pages ❍ TV/Radio Ad ❍ Insurance Co. Other:_____

The following information is requested for our grant and federal reporting requirements

Marital Status *(circle one)* Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership

Race *(circle one)* Black/African-American Asian Caucasian Native American/Alaska Native Pacific Islander/Native Hawaiian Mixed Race Other Unknown **Ethnicity *(circle one)*** Hispanic/Latino Not Hispanic/Latino

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth (required) ____/_____/_____ SS# _____ Gender (circle) Male Female

Mother's Name (minors only) _____ Father's Name (minors only) _____

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____ _____

Guarantor's Signature (required) **Date**

Terms of Admission

Financial Terms: I understand that if I am insured with a BCNH contracted insurance company, BCNH is required to submit claims on my behalf. I also understand that I will be responsible for all charges whether or not they are covered by my insurance. Some procedures may be considered non-covered services and I will be required to make payment in full at the time of service. I understand that there is a cancellation policy and that I may be billed for missed appointments or appointments cancelled with less than 24 hours notice. I understand that finance charges will begin accruing on accounts that are 60 days past due at a rate of 1.5% per month. I further understand that overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Bastyr Center for Natural Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our medical records office at (206) 834-4151.

I hereby acknowledge that I have received a copy of Bastyr Center for Natural Health's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Bastyr has made a good faith effort to obtain my acknowledgement.

X _____ _____

Patient's Signature Date

X _____ _____

Guardian/Representative's Signature Date

X _____

Relationship to Patient/Representative Authority