WALK-IN HEALTH CLINIC INCORPORATED

Date _____-_____-_____

Last Name _____ First _____ Middle _____ Male ☐ Female ☐

DOB _____-_____-_____ Age_____ SSN _____-_____-_____ Do you prefer to go by any other name? _____

Mailing address _____ Apt _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ Work Phone_____

IMPORTANT! Do we have permission to leave a detailed message with lab and x-ray results? ☐**Yes** ☐**No** At which #? ☐**Home Phone** ☐**Cell Phone**

Employer _____ Full time☐ Part time☐ Retired☐ Student (full time)☐ Student (part time)☐

Single☐ Married☐ Divorced☐ Legally Separated☐ Widowed☐ Spouse name _____ Phone _____

Emergency Contact _____ Phone _____

Medical History (for additional space use backside of form)

Prescription medications _____

Allergies/History _____

Primary Care Provider _____ City _____ State _____

Do you smoke cigarettes? Yes☐ No☐ If yes, how often? _____ **Last Tetanus Update**_____

Do you drink alcohol? Yes☐ No☐ If yes, how often? _____

Insurance Information

Primary Insurance Company_____ Identification # _____ Group# _____

Policy Holder _____ Birthdate _____-_____-_____ Relation to patient _____

Mailing address _____ Apt _____ City _____ State _____ Zip_____

Secondary/Supplemental Insurance _____ Identification # _____ Group# _____

Policy Holder _____ Birthdate _____-_____-_____ Relation to patient _____

Mailing address _____ Apt _____ City _____ State _____ Zip_____

Financial Policy

We bill most insurance companies, provided we have a copy of your insurance card and a mailing address in which to submit claims. If an insurance card is unavailable, verification of the benefits must be made prior to service. Full payment on account is expected within 60 days. We regret we cannot accept HMO plans. It is the patient's responsibility to acquire a referral if one is required by their insurance company to be seen at our office. It must be received prior to the visit.

Insurance is a contract between you and your insurance company. We are not a party to this contract, in most cases. We file insurance claims as a courtesy to our patients. We do not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc. other than to supply factual information as necessary to facilitate claims processing. Please be advised that some consultations are processed as a 'preventative care' benefit (i.e. sports physicals, CDL physicals, travel consultations) and can affect your benefit reimbursement from your insurance company.

Payment from patients paying privately is expected at a time of service. We accept cash, checks and Visa/MasterCard as forms of payment. An office co-pay as indicated by your insurance is also due at a time of service. Accounts past due 30 days may be assessed interest at 1% a month or 12% annually. Accounts exceeding 90 days are considered delinquent and will be referred to an outside agency for collection. An account that is referred to outside collection will be assessed a $25.00 collection fee and may result in termination of medical services from our clinic. NSF check may also result in this action. If future care is provided, it will be on a cash or credit card basis only, regardless of insurance.

Please be advised that you may incur additional fees if lab and/ or x-ray have been ordered in the course of your medical visit. They will be billed to you by these facilities and are separate from the Northwest Walk-In Health clinic fees.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all charges whether or not paid by insurance. I also authorize the physician to release all information, regardless of nature, that they may be required in the processing of my claim. I authorize the use of this signature on all my insurance submissions.

Signature _____ **Date** _____

How did you hear about us? ☐Phone Book ☐Internet ☐Facebook ☐Insurance ☐Friend/Family ☐Employer ☐Physician ☐Other