PATIENT INFORMATION

Last Name	**First Name**	**Middle Initial**	**Nickname**

Date of Birth	**Social Security Number**	**Gender** (circle one) *Male Female Transgender MTF/FTM (Specify)*

Marital Status (circle one) *Single Married Divorced Separated Widow Life Partner*

Ethnicity (circle one) *White Native American Hispanic Asian/Pacific Islander African American Other (?)*

Mailing Address	**Apt #**	**City**	**State**	**Zip**

Physical Address *(if different than mailing)*	**Apt #**	**City**	**State**	**Zip**

Home Number *(circle preferred number)*	**Mobile**	**Employer**	**Work Number**

Spouse	**Spouse Mobile**	**Spouse Work**

How did you hear about us?	**Email Address**

EMERGENCY CONTACT INFORMATION

Name	**Relationship to Patient**	**Phone Number**

INSURANCE INFORMATION

Primary Insurance Carrier	*Subscriber Name*	*Insured's Birthdate*
Identification Number	*Group Number*	*Copay Amount*
Secondary Insurance Carrier (if applicable)	*Subscriber Name*	*Subscriber Birthdate*
Identification Number	*Group Number*	*Copay Amount*

PERSON RESPONSIBLE FOR BILL (for minor child)

Last Name	**First Name**	**Middle Initial**	**Relationship to Patient**

Address	**City**	**State**	**Zip**

Home Number	**Mobile Number**

By signing below, I acknowledge that I have received copies of Country Homes Nurse Practitioners financial, privacy, office, and no-show policy. I understand these policies and agree to the terms in them. I also understand that if I do not comply with the terms of the Country Homes Nurse Practitioner office policies, that I may be discharged from the practice.

_____ _____

Patient or Legally Authorized Representative Signature **If other than self, what relationship**

_____ _____

Printed Name **Date Signed**

Country Homes Nurse Practitioners

9103 N Division St, Spokane, WA 99218
Phone: (509)467-6060 Fax: (509)467-6518

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

With my signature below, I acknowledge that I have received a copy of Country Homes Nurse Practitioners Financial Policy, and:

I authorize the release of my information to my insurance plan for billing purposes and authorize them to pay my provider directly for services rendered.

I understand that I am responsible for all balances for non-covered services, deductible, co-payment and co-shares as deemed patient responsibility by my insurance.

I understand that if my provider is not a network provider for my plan, that I may be responsible for a larger portion or all charges for services provided to me by my provider.

I have been informed that for a second or third no-show that I will be charged a fee for that no-show which will be due prior to scheduling my next appointment.

I understand that Country Homes Nurse Practitioners does not bill automobile accident (MVA) claims and that I am responsible to pay at the time of service for this type of appointment. I know that I will be provided a receipt for payment for services so that I may submit it to my motor vehicle insurance also known as PIP, for reimbursement directly to me. I understand that MVA services are not billable to my private insurance due to third party liability.

I understand that If I am seen for a Department of Labor & Industries and the claim is denied, these claims may not be billed to my private insurance due to third party responsibility restriction and that I will be responsible for charges in their entirety.

I understand in the event that I am sent to collections there will be an additional collection fee added to my account balance at the time it is listed with the outside collection agency. I am responsible to pay that fee as well as account balance in full prior to scheduling my next appointment. I understand that if my collection account remains unpaid that I may be dismissed from the practice.

_____ _____

Signature of Patient/Legally Authorized Representative **Date Signed**

_____ _____

Printed Name of Signer **Relationship to Patient**