**Please use: BLACK INK**

**Northwest Pediatric Center**

**Please include all children who have the same biological parents and live in the same household on one Registration Form**

| | |
|---|---|
| **Account #** | |
| **First Name** | |
| **Middle Initial** | |
| **Last Name** | |
| **Birthdate** | _______/_______/_______ |
| **Sex** | ______ Male ______Female |
| **Primary Language Spoken** | ___ English ___ Spanish List Other_____________________ |
| **Ethnicity** | ___ Not Hispanic ___Hispanic ___ Unknown |
| **Race** check all that apply | ___ White ___ Native American ___ Asian<br>___ Black ___ Pacific Islander |
| **School/Employer** | |

Mailing Address: ______________________________________________________________________________
Street City State Zip Code

Social Security Number: __________________________ Employer: _______________________________________ Occupation: _________________________

Email Address: __________________________________________ Would you like access to your medical record through our Patient Portal? Yes_____ No_____

Primary Contact Number: _________________________________________ Is this a _____ Cell Phone _____ Home Phone

Secondary Contact Number: ________________________________ Is this a _____ Cell Phone _____ Home Phone

**How would you like appointment reminders and recalls?** Email _____ Text to Cell _____

**IF INSURANCE CARDS ARE NOT PRESENTED AT EACH VISIT YOU WILL BE CONSIDERED SELF PAY**

Are you covered by Apple Health or Provider One? _____ Yes _____ No

**Primary Insurance:**

Subscribers Name: __________________________________________________________ Sex: ___M ___ F Subscribers DOB: _____/_____/_____

Relationship to Patient: _____________________________________________________

Name of Insurance Company: ______________________________________________________________________________

Employer (Group) Name: __________________________________________________________________________________

Subscribers ID# _______________________________________________________________ Group #: _____________________________________________

**Secondary Insurance:**

Subscribers Name: __________________________________________________________ Sex: ___M ___ F Subscribers DOB: _____/_____/_____

Relationship to Patient: _____________________________________________________

Name of Insurance Company: ______________________________________________________________________________

Employer (Group) Name: __________________________________________________________________________________

Subscribers ID# _______________________________________________________________ Group #: _____________________________________________

**Emergency Contact**: ________________________________________Relationship to Patient ______________________ Phone: _____________________

**HIPAA Privacy Practices:** I acknowledge that Physician's Notice of Privacy Practices has been offered to me. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician/provider has reserved the right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available to me.

**Signature:** _______________________________________________________________________________ **Date** _______________________

I understand that I am financially responsible for all charges, regardless of insurance coverage. Payment is required at the time of service unless other arrangements have been made in advance with the billing department. All insurance claims are your responsibility. Copays and deductibles must be paid at the time of service. If it becomes necessary to assign collection of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I have read the above policy. I hereby assign to the physician/provider all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance plan.

**Signature:** ____________________________________________________________________________ **Date:** _________________________

**Print Name**: ____________________________________________________________________________

**Preferred Pharmacy:** ________________________________________ **Location:** ________________________________

Verbal Communication To:

________________________________
(Name)

________________________________
(Address)

________________________________
(Phone Number)

________________________________
(Relationship to Patient)

Release From:

**Northwest Pediatric Center and Providers**

**1911 Cooks Hill Rd.**

**Centralia, WA 98531**

I, ____________________________________________________________ hereby grant

**Northwest Pediatric Center and Providers**

Permission to verbally discuss to the above designated person the items checked below:

__ Communication necessary to coordinate ongoing care
__ Drug or Alcohol history
__ HIV
__ Immunization record
__ Laboratory reports
__ Medications
__ Psychiatric disorders/mental health
__ Reproductive Care
__ Sexually transmitted diseases
__ Summary of medical history
__ Account Balance(s)
__ Insurance questions/concerns

__ Other: ____________________________________________________________________________

I understand that this consent allows verbal communication of the designated records for the following period:

__ 12 months from today's date

I also understand I may revoke this consent in writing at any time, but that such revocation becomes effective only when received by

**Northwest Pediatric Center and Providers**

and that disclosure made before such revocation is received is not affected.

**Northwest Pediatric Center and Providers**

clinical and administrative staff maintains patient confidentiality in strict compliance with state and federal laws. These practices are supported by policies and procedures. These procedures are reviewed and, if necessary, revised on a regular basis. We will ensure that HIPAA regulations on re-disclosure are followed. However, after the information leaves this clinic, we cannot guarantee privacy protection of your health information.

Signature: ______________________________________________ Date signed: __________________
(Patient/Requestor)

Printed name: __________________________________________ Witness: ______________________