1033 Regents Blvd., Suite 102
Fircrest, WA 98466
Phone: (253) 564-1115 • Fax: (253) 565-4552

Print patient name:			Nickname:	
Address:			❑ Male ❑ Female	Date of Birth:
City:	State:	Zip Code:	Pt. Cell # (if applicable):	

Please circle applicable: Parent Step-Parent Foster Parent Grandparent Other________ ***Does child reside with you? Yes No***

Print full name:			Nickname:	
Address:			❑ Male ❑ Female	Date of Birth:
City:	State:	Zip Code:	Social Security #:	
Primary contact #: Home Work Cell		Secondary contact #: Home Work Cell		
Email Address:		Employer:		Marital Status:

Please circle applicable: Parent Step-Parent Foster Parent Grandparent Other________ ***Does child reside with you? Yes No***

Print full name:			Nickname:	
Address:			❑ Male ❑ Female	Date of Birth:
City:	State:	Zip Code:	Social Security #:	
Primary contact #: Home Work Cell		Secondary contact #: Home Work Cell		
Email Address:		Employer:		Marital Status:

Primary Insurance Name:	Identification #:		Group #:
Subscriber Name:	Subscriber's DOB:	Effective date:	
Secondary Insurance Name:	Identification #:		Group #:
Subscriber Name:	Subscriber's DOB:	Effective date:	

If Listing State Medicaid as Primary Coverage, please read and initial the statement below:

I attest that there is no other coverage that could be primary to the state Medicaid. __________

Pharmacy Name:	Phone #:
Pharmacy Address:	

Emergency contact other than parent:	Address:	Relationship to child:
Primary contact #: Home Work Cell	Secondary contact #: Home Work Cell	

PLEASE READ AND SIGN BACK

Thank you for choosing University Place Pediatric Clinic as your health care provider.
Our goal is to provide the highest quality medical services to our patients at a reasonable cost.

Please read the following payment terms and feel free to speak to a bookkeeping representative if you have any questions or concerns.

- If you have insurance, please be prepared to **present your insurance card** at each visit. We are happy to submit a bill to all major carriers as well as most secondary carriers when all necessary information to do so has been provided to us.

- Please note that your insurance coverage and benefit package is an arrangement between you and your insurance carrier. You are responsible to be aware of your benefits and to contact your carrier directly when issues arise. This includes timely payment of claims, denials, rebilling, contracted providers and other such issues. Many insurance plans have limitations on benefits, especially for preventive care (well child care &/or vaccinations.) Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefits questions. We cannot quote nor do we guarantee insurance benefits. Regardless of insurance, all services provided are the financial responsibility of the patient or the parent(s) of patients who are minors.

- Co-payments are due at the time of service. Any co-payments not paid at the time of service may be subject to a $10.00 administration fee.

- Uninsured patients are expected to pay for services in full at the time of service unless other prior arrangements have been made with the Billing Department.

- We offer a “prompt pay “discount on most care and treatment when paid in full at the time of service.

- As a courtesy, we will bill third party payers (such as auto insurance relating to motor vehicle accidents) when provided with complete insurance information at the time of service. Balances for third party claims are subject to the same payment terms as other services received.

- Payments for services rendered are due within 30 days of receiving service. We accept cash, credit cards, and bank debit card. In many cases we can also accept personal checks and money orders. If you are unable to pay in full within 30 days, please contact our office to see if you qualify for a payment plan. If approved, regular monthly payments must be made until the balance is paid in full.

- Accounts may be assigned to an outside collection agency and reported to the credit bureaus when the personal balance is over 120 days old and/or payment plan payments are missed. Patients whose account has been assigned to outside collections are responsible for all agency and/or legal fees incurred. When an account is turned over to outside collections, care is discontinued.

Additional Charges:

1.5% monthly finance charge (18% APR) added to accounts with personal balance over 60 days old, including those for which a payment arrangement has been established. A minimum of $3.00 will be assessed monthly on all account balances 60 days or older. A **$25 Returned check** fee will be added to accounts for which check payment is not honored by the bank.

NOTICE OF PRIVACY PRACTICES: We keep a record of all services provided to each patient. You may ask to see and request a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information by contacting our records custodian. **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

I authorize treatment of the above child as deemed necessary and appropriate by the attending physician, and certify that I have legal standing to consent treatment. I authorize my insurance benefits to be paid directly to UNIVERSITY PLACE PEDIATRIC CLINIC for services rendered. I acknowledge that the Notice of Privacy Practices has been made available to me. I authorize UNIVERSITY PLACE PEDIATRIC CLINIC to release any information requested by the insurance company with regards to payment of benefits. I accept the payment terms, and acknowledge financial responsibility for all charges not covered by insurance. I understand that I may be billed directly from other lab and/or x-ray facilities for charges incurred for diagnostic services.

______________________	______________________	______________
Signature	Relationship to patient	Date