Patient Demographics for White River Family Care:

Date: _____ Insurance and Driver License cards copied: _____

Legal Name(First, M, Last): _____
Mailing Address: _____
City:_____ State:_____ Zip:_____
Date of Birth: _____ SS#: _____
Cell Phone: _____ Home Phone: _____
Gender: _____ Marital Status: _____
Employer / School: _____
Email address: _____

Financial Responsibility: (Person bringing patient if not self. We do not get in the middle of custody issues).

Name of Responsible Party: _____
Relationship to Patient: _____ SS#: _____
Mailing Address: _____
Contact Cell/Home: _____

Insurance Information:

Primary Insurance Name: _____
Insurance ID#: _____ Group#: _____
Subscribers Name, Date of Birth and SS#:_____
_____
Secondary Insurance Name: _____
Insurance ID#: _____ Group#: _____
Subscribers Name, Date of Birth and SS#: _____
_____

_____

Name:_____Date: _____

Meaningful Use Required by the Federal Government:

Race: (circle one): American Indian – Asian – African American – Asian – Hispanic or Latino – Other Race – Pacific Islander – White – Decline to specify

Ethnicity: (circle one): Hispanic or Latino – Not Hispanic or Latino – Decline to specify

Primary Language:_____

Emergency Contact Information:

In case of an emergency who do you allow us to speak to on your behalf? Please list name, contact and relationship info.

	Name:	**Contact#:**	**Relationship:**
1.	_____	_____	_____
2.	_____	_____	_____

Due to HIPAA privacy laws we ask that you fill this form out so that we know who we can disclose your medical or financial information with.

Release of Information Medical and or Financial:

Please list only the names of people that you will allow us to disclose your private medical and or financial information with below:

	Name:	**Contact#:**	**Relationship:**
1.	_____	_____	_____
2.	_____	_____	_____

This will remain in force while you are a patient at this clinic or until you change any of the above information.

We do not bill Tertiary or Third Insurance Plans.

If you are being seen for an MVA, be aware we only bill for PIP Claims. (Personal Injury Protection). Otherwise, you may pay out of pocket or contact your regular insurance subrogation department.

We do not get in the middle of any custody issues, so whoever is bringing in a dependent child, is financially responsible for paying any claims not otherwise paid by the insurance provided. Regardless of parenting plan. Per WRFC

ASSIGNMENT OF BENEFITS:

I authorize payment to be made directly to White River Family Care, LLC for all services rendered. I authorize WRFC to release any information required to process medical claims on my behalf. I realize by completing and signing the financial responsibility information that I am legally responsible for any and all charges that my insurance plan does not cover. I realize that all balances are due no later than 30 days. All checks returned for any reason will be subject to a $20.00 processing fee. This will be binding while I am a patient at WRFC.

Signed: _____ Dated: _____
Print Name: _____
Relationship to patient:_____

WHITE RIVER FAMILY CARE, LLC POLICIES AND PROCEDURES:
PO BOX 1268/ 305 NORTH RIVER AVE.
BUCKLEY, WA. 98321 PHONE: 360-829-0625 FAX: 360-829-9860

I hereby agree that if the medical coverage I am supplying to WRFC, for any reason, does not cover the office visits or other medical procedures, etc. I will be fully responsible for the expenses incurred. ALL COPAYS ARE DUE AT THE TIME OF SERVICE. ALL INSURANCE CHANGES MUST BE UPDATED UPON NOTICE OF CHANGE. THIS IS YOUR RESPONSIBILITY.

All accounts must be paid in full within 30 days of patient receiving their Explanation of Benefits or a Statement from WRFC. We accept: cash, check, debit, credit and HSA cards.

WRFC reserves the right to Charge patients a "NO SHOW" charge of $50.00 if the patient fails to show for scheduled Physical or an Appointment that requires more time. Or is consistently no showing scheduled appointments. After the 3rd no show the patient is terminated from the practice, WRFC. We also reserve the right to terminate the Patient/Provider relationship due to abuse of staff, drug seeking behavior, no shows or failure to pay account balances.

I have read and understand the "Notice of patient privacy practices and consent to use/disclose patient information" otherwise known as HIPAA

No Surprise Billing Act and Prompt Pay Discounts Disclosure:

I have been given the fee schedule for "No surprise billing Practices" for out of network services. We do offer our cash paying patients a prompt pay discount. This discount is only available to our patients who do not have medical insurance and are paying in full at the time of service. The prompt pay discount applies to eligible services. It does not apply to patient responsibility beyond insurance coverage, such as copays, deductibles or co-insurance. Any questions you may ask to speak to a clinic representative for further details.

RETURNED CHECK POLICY:

A fee of $20 will be charged for any check that is returned from the bank as a result of insufficient funds or a closed account.

PAYMENT FOR FORMS COMPLETION:

There will be a charge for completion of forms of $25 payable at the time of request. There may be a higher charge applied to complex forms and or an office visit required to properly fill out the forms.

Signed: _____ Dated: _____
Print Name: _____
Relationship to patient:_____