

Patient Information Form

Last Name _____ First Name _____ Middle Name _____
Date of Birth (Required) ____/____/____ Gender ____ Other names that records may be kept under _____
Address _____ City _____ State _____ Zip _____
SS# _____ Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
May we leave confidential voice-mail messages for you at any of the above numbers? No Yes (specify) Home Work Cell
Are you a Bastyr or LIOS employee, student, or significant other of a student or staff member? No Yes (specify) _____
Are you a student at another university or college? Y N What is your current status? FT PT Are you currently employed? Y N
Employer/School _____ Will you be applying for our reduced rate? Y N
Mother's Name (minors only) _____ Father's Name (minors only) _____
Emergency Contact Name _____ Contact's Phone (____) _____
Relationship to Emergency Contact _____ Do you have special needs? _____
Are you visually impaired? Yes No Are you hearing impaired? Yes No Do you need an interpreter or TTY Line? Yes No

How did you hear about us? Newspaper Ad News Story Mailer/Flyer Website Workshop/Event Medical Referral
 Friend/Family Yellow Pages T.V. Ad Insurance Co. Other: _____

The following information is requested for our grant and federal reporting requirements

Marital Status (circle one) Single/Never Married Married Divorced Separated/Not Divorced Widowed Domestic Partnership
Race/Ethnic Origin African/African-American Asian Caucasian Native American Pacific Islander/ Native Hawaiian Mixed Race Other
Number of members in your household _____ **Gross annual household income** _____/year

Guarantor Information

This section must be completed if someone other than the patient is financially responsible for the patient's account.

Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ State _____ Zip _____
Phone (____) _____ Date of Birth (required) ____/____/____ SS# _____ Gender (circle) Male Female

I hereby acknowledge that I am financially responsible for payment of all services rendered to the above-named patient and that I am subject to all financial terms listed below.

X _____
Guarantor's Signature **Date**

Terms of Admission

Financial Terms: I understand that if I am providing insurance billing information that I am responsible for all charges whether or not they are covered by my insurance. I understand that there is a cancellation policy and that I may be billed for missed appointments or appointments cancelled with less than 24 hours notice. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.

Privacy Terms: We keep a record of the healthcare services we provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. Bastyr Center for Natural Health is required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information, describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information at our clinic, wish to inquire about your rights or if you wish schedule an appointment to view your medical record, please call our medical records office at (206) 834-4151.

I hereby acknowledge that I have received a copy of Bastyr Center for Natural Health's Notice of Privacy Practices. Should I fail to sign this form, I acknowledge that Bastyr has made a good faith effort to obtain my acknowledgement.

X _____
Patient's Signature Date

X _____
Guardian/Representative's Signature Date

X _____

