# CASCADE PEDIATRICS

❒ Insurance Update ❒ Change of Address

## CHILDREN(S) INFORMATION

Legal Last Name: ______________________________ First: ________________ M.I. ____ Date of Birth: ____/____/________ ❒ M ❒ F

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Referred to Cascade Pediatrics by: ____________________________________________________________________________

## PARENT/CONTACT INFORMATION

| Mother or Guardian Name: Last | First | MI | |
|---|---|---|---|
| Address: | City: | St: | Zip: |
| Home Phone: ( ) | Cell Phone: ( ) | Employer: | Employer Phone: ( ) |
| Father or Guardian Name: Last | First | MI | |
| Address: | City: | St: | Zip: |
| Home Phone: ( ) | Cell Phone: ( ) | Employer: | Employer Phone: ( ) |

## INSURANCE INFORMATION - PLEASE PROVIDE INSURANCE CARDS TO FRONT DESK

| PRIMARY INSURANCE: | | EFFECTIVE DATE: | |
|---|---|---|---|
| Subscriber Name: Last | First | MI | |
| Subscriber's Soc Sec Number: | Subscriber's Birthdate: | Relationship to Patient : | Sex of Subscriber: ❒ Male ❒ Female |
| **SECONDARY INSURANCE:** | | | |
| Subscriber Name: Last | First | MI | |
| Subscriber's Soc Sec Number: | Subscriber's Birthdate: | Relationship to Patient : | Sex of Subscriber: ❒ Male ❒ Female |

## RELEASE, ASSIGNMENT AND FINANCIAL AGREEMENT

I hereby consent to the use and disclosure of health care information regarding person(s) named above for the purposes of health care operations of this provider. Patient has the right to review the health care provider's privacy notice, to request restrictions on health care provider's uses and disclosure of the health care information and to revoke this consent to release information. I authorize treatment of the person(s) named above and agree to pay all fees for such treatment. **THE PARENT OR GUARDIAN WHO BRINGS THE CHILD FOR HIS/HER INITIAL VISIT IS RESPONSIBLE FOR PAYMENT INDEPENDNT OF WHAT A DIVORCE DOCTRINE MAY STATE. REIMBURSEMENT MUST BE MADE BETWEEN DIVORCED PARENTS. WE WILL NOT INTERVENE**. I hereby authorize my insurance benefits to be paid directly to the health care provider of service and I am financially responsible for non-covered services. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. Any accounts carrying a balance of which no payment has been received from the 2nd statement on, will incur a $5.00 rebilling fee. I have also been informed of the $20.00 fee (per RCW 2a.3-515) on returned checks. In the event it should become necessary to place for collection an unpaid balance due to services rendered to the above named person(s). I/we agree to pay interest, collection fees, and should legal action be filed, reasonable attorney's fees, filing fee and any other costs the courts determine proper.

Parent or Guardian ________________________________________________ Date ____________________________

**THERE IS A $10.00 CHARGE FOR AFTER HOURS CONSULTING NURSE PHONE CALLS.**
**INSURANCE COMPANIES DO NOT COVER THIS CHARGE.**