

CASCADE PEDIATRICS

PATIENT INFORMATION

Child 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:			
Subscriber Name:			
Last	First	MI	
Subscriber's Soc Sec Number:	Subscriber's Birthdate:	Relationship to Patient :	Sex of Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> Female
SECONDARY INSURANCE:			
Subscriber Name:			
Last	First	MI	
Subscriber's Soc Sec Number:	Subscriber's Birthdate:	Relationship to Patient :	Sex of Subscriber: <input type="checkbox"/> Male <input type="checkbox"/> 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. 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. I am financially responsible for a filing fee, balances over 60 days may incur a billing fee of 1% per month (12% APR), (RCW 19.52), with a minimum charge of \$1.00 monthly. 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 \$18.00 CHARGE FOR AFTER HOURS CONSULTING NURSE PHONE CALLS.