Patricia Spach, MN, ARNP
4026 NE 55th St, Suite E
Seattle, WA 98105
Telephone: (206) 729-2681

THIS SHEET MUST BE FILLED IN COMPLETELY

Patient Information

Date_____ Client's Social Security #_____

Client's First Name_____ Last Name_____MI_____

Address_____ City_____ State_____ Zip___

Telephone (Home)_____ (Work)_____Cell_____

Birthdate_____/_____/_____ Age_____ Gender __F __M

Marital Status: S___M____D___W____Other_____

Name of Spouse/Guardian_____Birthdate:_____/_____/_____

Phone_____Address_____ City_____ State___

____Zip_____

E-MAIL_____

REFERRED BY:_____Phone:_____

Person Responsible for Payment_____

Signature of Person Responsible for Payment **X**_____ (Must be signed)

Emergency Information

In case of emergency, contact:

Name (1) _____Relationship_____ Phone_____Work_____

Address_____City_____ State_____ Zip_____

Name (2) _____ Relationship_____ Phone Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Employment Information

Place_____Occupation_____ Phone_____

Spouse: Place_____Occupation_____Phone_____

Insurance Information

Primary Insurance_____

Address._____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth _____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Secondary Insurance:_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

HIPAA INFORMATION: Instructions for the office when returning phone calls or reminding you about appointments. I authorized the office to contact me at: [ ] Home [ ] Work [ ] Cell and May leave messages at: [ ] Home [ ] Work [ ] Cell
I authorize the office to leave detailed messages about appointments/phone calls: [ ] YES [ ] NO If you prefer us to leave messages with a specific individual please list them below: 1._____
2._____ 3._____

Assignment and Release

I, the undersigned certify that I have insurance coverage with_____

Name of the insurance company(ies)

And assign directly to Patricia Spach, MN, ARNP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid or not by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature **Relationship** **Date**