Personal Contact, Insurance Information & Privacy Policy Form

*Name: ____

*Date of Birth:_______________ Gender: M F TG Marital Status: Single Married Other

*Address:___________________________City: _________________ST: _____Zip: ______________

*Phone Numbers: Home:( )__________________ Cell:( )_________________________

*Email: ______________________________Employer:________________________________

Primary Insurance Provider (Please check all that apply):

- ○ **Aetna** **Member ID#**: ____
- ○ **First Choice** **Medical Co-pay for Office Call**: $__________Inquire: ??_________
- ○ **Premera** **Referral Needed by MD Yes No**
- ○ **Regence** **Primary Care Physician:** __________________________________
- ○ **Blue Cross** **Physician Phone Number**:_________________________________
- ○ **LifeWise** **Secondary Insurance Provider**:____________________________
- ○ **Cigna** **Secondary Insurance Member ID#:**__________________________
- ○ **Other Health Insurance Not Listed:** ____

***Emergency Contact: ___________________Relationship____________Phone: ( )___________**

<u>Privacy Notice</u>:

I have been informed and understand the following notices that describe information that may be used, disclosed and how I can get access to this information regarding my health information and privacy related to my healthcare:

- Understanding Your Health Record/Information
- Your Health Information Rights
- The Responsibilities of Beve Kindblade MS, RD, CD as your Healthcare Practitioner in Maintaining your Privacy related to Healthcare
- How to Obtain More Information or To Report a Problem
- Examples of Disclosures for Treatment, Payment and Health Operations
- Other Uses or Disclosures

<u>*Appointment Cancellation less than 48 hours in advance and No Show for Appointments:</u> I agree to pay a **$50.00** Late Cancellation Fee if I cancel an appointment less than 48 hours in advance or do not show for an appointment. The fee must be paid within 2 weeks of the occurrence. I understand I will receive an invoice for the fee by mail from Beverly Kindblade, MS, RD, CD. I understand that the fee will be waived in cases of emergency or illness or unexpected change in work schedule.

<u>*Health Insurance Payment Authorization</u>:

I authorize my health insurance benefits to be paid directly to the provider. I am responsible for any balance due after insurance benefits are paid. I authorize the provider or Insurance Company to release any information for these claims. If my insurance company does not make payment within 60 days of the claim being submitted, I agree to pay for services, receive an invoice from the provider, Beverly Kindblade, and submit the payment for reimbursement by my insurance company.

***Signature**:____ ***Date**:______________