



*Dr. Susan Jones*

*Naturopathic Physician*

17651 1st Ave. S. Suite #101 Normandy Park, WA 98148  
(206) 241-3836 www.susanjonesnd.com

Today's Date \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex: M / F

Other Names or Nicknames your records may be kept under \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_ (to receive newsletter)

Mother's Name (for minors) \_\_\_\_\_ Father's Name (for minors) \_\_\_\_\_

Name and Phone Number of Emergency Contact Person \_\_\_\_\_

How did you hear about me? (Circle One) Advertisement Mailer/Flyer Website

Street Sign Workshop/Event Referral Insurance Company Other \_\_\_\_\_

\*If you were referred to us by a friend or family member, please give us their name so we may send them a letter of thanks:  
\_\_\_\_\_

**Primary Insurance Information**

Primary Insurance Company & Plan Name  
\_\_\_\_\_

Insurance Claims Address  
\_\_\_\_\_

ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Birth of Insured \_\_\_\_\_

Relationship to Insure \_\_\_\_\_

**Referral Information**

Does your plan require you to have a referral from your Primary Care Provider? Yes / No

PCP's Name \_\_\_\_\_ Clinic Phone \_\_\_\_\_

PCP'S Clinic Name & Location  
\_\_\_\_\_

**OVER**

**Assignment and Release**

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Susan Jones all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Guardian \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to minor child \_\_\_\_\_

**Cancellation Policy**

Cancellation of visits must be made with at least 24 hours notice. You will be billed \$45 for missed appointments where a timely cancellation has not been made. Insurance will not provide benefits to cover missed appointments, so the charge will be made directly to the patient. Payments are due within 2 weeks and prior to next appointment.

I have read and agree to the terms of the cancellation policy. Initial Here \_\_\_\_\_

**Patient Responsibility**

I understand that my health insurance is an agreement between myself and the insurance company and that I am responsible regarding coverage of treatment. I understand that I am financially responsible for all charges except those paid for by my insurance. If my insurance covers partial services or no services at all I understand that I will be billed for the balance due. If payments are not received by the date indicated on the bill, I understand that there may be a 5% charge of the amount due for each delinquent month.

If I do not have insurance coverage or Dr. Jones is not contracted with my insurance carrier, I understand that I am responsible for payment in full at the time of service.

I have read and agree to the terms of the patient responsibility policy. Initial Here: \_\_\_\_\_