One Earth
Natural Medicine Clinic

636 SW 152nd St, Ste D Burien WA 98166
206-838-7704 www.oneearthmedicine.com

Appointment 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_____

Marital Status: Single Domestic Partner Married Divorced Widow

Employed _____ Student _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Work Phone (_____)_____ - _____

Cell Phone (_____) _____ - _____ Phone # preferred to be contacted at: Hm /Wk /Cell

Email Address: _____

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:

_____

Current Physician Contact:

Primary Care Physician: _____ Phone#:_____

Clinic Name & Location: _____

Specialist or Other Physicians that you are under the care of:

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

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 Insured _____

OVER →

Referral Information

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

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: _____