

# HOPE CLINIC

A Division of Developmental Vision Associates, PLLC

## \* YOUNG ADULT PATIENT INFORMATION (13-17 YEAR OLD)

TITLE \_\_\_\_\_ LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_ SUFFIX \_\_\_\_\_

NICKNAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ & ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ FATHER'S WORK PHONE (\_\_\_\_) \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_\_ MOTHER'S WORK PHONE(\_\_\_\_) \_\_\_\_\_

SS# \_\_\_\_\_ E-MAIL \_\_\_\_\_

(If applicable for insurance billing purposes)

Do you prefer correspondence via ( ) e-mail ( ) regular mail, or ( ) both

BIRTHDATE [00/00/0000] \_\_\_\_\_  
[month/day/full year]

SEX (M) (F) ( ) FULL-TIME STUDENT ( ) PART-TIME STUDENT

FATHER'S NAME \_\_\_\_\_ CHILD'S SCHOOL NAME \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ CHILD'S SCHOOL DISTRICT \_\_\_\_\_ GRADE \_\_\_\_\_

IF PARENTS ARE SEPARATED OR DIVORCED, WITH WHOM DOES CHILD LIVE? \_\_\_\_\_

WHO MAKES MEDICAL DECISIONS? \_\_\_\_\_

PERSON COMPLETING QUESTIONNAIRE \_\_\_\_\_

SIBLINGS:	NAME	M/F	BIRTHDATE	GRADE or OCCUPATION
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IF REFERRED, WHOM MAY WE THANK FOR THIS REFERRAL?

PATIENT REFERRAL \_\_\_\_\_

PROFESSIONAL REFERRAL \_\_\_\_\_

OTHER \_\_\_\_\_

Tacoma Office  
Allenmore Terrace Office Bldg., Ste. 215  
(HomeStreet Bank Building)  
3315 South 23<sup>rd</sup> Street  
Tacoma, WA 98405-1615  
(253) 925-1288

Bellevue Office  
Place 10 Building, Ste. 302  
12301 NE 10<sup>th</sup> Place  
Bellevue, WA 98005-2487  
(425) 462-7800  
Fax: (425) 455-3019  
Toll Free: (866) 251-5581

Silverdale Satellite Clinic  
Creekside Bldg., Ste 201  
9633 Levin Road  
Silverdale, WA 98383  
(360) 613-0181

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## DEPENDENT / RESPONSIBLE PARTY

**FATHER** \_\_\_\_\_ SS # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY & ZIP \_\_\_\_\_

(If different from above)

EMPLOYER \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

**MOTHER** \_\_\_\_\_ SS # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY & ZIP \_\_\_\_\_

(If different from above)

EMPLOYER \_\_\_\_\_ WORK PHONE (\_\_\_\_\_) \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/ZIP \_\_\_\_\_

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## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY \_\_\_\_\_ PHONE # \_\_\_\_\_

(Please bring Insurance Card with you.) Place of Employment \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_ NAME OF THE INSURED \_\_\_\_\_

POLICY GROUP # \_\_\_\_\_ Birth Date of the Subscriber \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE & ZIP \_\_\_\_\_

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SECONDARY INSURANCE COMPANY \_\_\_\_\_ PHONE # \_\_\_\_\_

(Please bring Insurance Card with you.) Place of Employment \_\_\_\_\_

INSURANCE ID# \_\_\_\_\_ NAME OF THE INSURED \_\_\_\_\_

POLICY GROUP # \_\_\_\_\_ Birth Date of the Subscriber \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE & ZIP \_\_\_\_\_

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## HIPPA PRIVACY POLICY

Please take a moment to read over and familiarize yourself with our Notice of Privacy Practices a copy of which is enclosed.

Please sign below that you have read, understand, and agree to our privacy policy practices.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### PERMISSION FOR MUTUAL EXCHANGE OF INFORMATION

### RELEASE OF CONFIDENTIAL INFORMATION

PATIENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

Permission is given for \_\_\_\_\_ to release  
(DO NOT FILL IN THIS LINE AT THIS TIME. IT IS FOR WHEN YOU NEED US TO RETRIEVE RECORDS FROM OTHER PROFESSIONALS OR AGENCIES OR VISA VERSA.)

records, correspond with and exchange any or all information regarding the above-named patient/student with Hope Clinic.

This information may include:

- case history
- testing records
- school records
- treatment summaries/progress reports
- psychological data
- medical information
- other records helpful to either party in providing treatment
- other:

Parent /Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called CareCredit, which allows you to start treatment today and spread payments over time.

PAYMENT OPTIONS:

- 1. Cash or Check
2. Major Credit Cards (Visa, MasterCard, Discover)
3. CareCredit (offering a variety of monthly payment plans)

What if I have insurance?

\*\*\*\*\* INSURANCE \*\*\*\*\*

Our clinic participates in a variety of insurance networks. Please ask our staff about insurance policies concerning your insurance carrier. All insurance eligibility must be presented and confirmed prior to provided services. If insurance eligibility cannot be confirmed you will be responsible for payment in full for all services and materials at the time of your visit. All fees are the full responsibility of the patient/parent/guardian. If your insurance carrier does cover the services received at Hope Clinic, our office will file an insurance claim (HCFA 1500) on your behalf as a courtesy. However, it is your responsibility to pay in full for any services or materials not covered by your insurance plan. If you prepay for any service or materials, any insurance payments we receive at a later date will be credited to your account and/or refunded to you. Insurance codes for pre-determination of benefits will be supplied upon request.

It is understood that an interest fee of 1 1/2% will be charged each month on all outstanding balances of 30 days or more. It is understood that Developmental Vision Associates, PLLC reserves the right to send to collections any account when lack of effort to satisfy unpaid balance(s) is shown. It is understood that should it become necessary for my account to be turned over for collections, I will be liable for any and all resulting collections and/or legal fees incurred. It is understood that failure on my part to adhere to this payment agreement will result in a break from treatment.

I acknowledge that I have read and received a copy of the foregoing agreement. I consent to treatment and I assume all financial responsibility for all treatment expenses.

Date \_\_\_\_\_

Signature of Patient/Responsible Party \_\_\_\_\_

Printed Name of Patient/Responsible Party \_\_\_\_\_

Printed name of patient if other than responsible party \_\_\_\_\_

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