HOPE CLINIC

A Division of Developmental Vision Associates, PLLC

*** ADULT PATIENT INFORMATION** (18 YEARS AND OLDER)

TITLE ____ LAST_____ FIRST _____ MI _____ SUFFIX _____

NICKNAME _____ **TODAY'S DATE** _____

ADDRESS_____

_____

CITY _____ STATE _____& ZIP _____

HOME PHONE (_____)_____ WORK PHONE (_____)_____

CELL PHONE (_____)_____ SPOUSE 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) ( ) EMPLOYED ( ) FULL-TIME STUDENT ( ) PART-TIME STUDENT

EM PLOYER/SCHOOL _____

PERSON COMPLETING QUESTIONNAIRE _____

RESPONSIBLE PARTY

SELF [Billing address if different from home address.]

ADDRESS _____ CITY & ZIP _____

BUSINESS ADDRESS _____

CITY _____ STATE/ZIP _____

WORK PHONE (_____)_____

NAME OF SPOUSE/SIGNIFICANT OTHER _____
[Billing address if different from home address]
ADDRESS _____ CITY & ZIP _____

BUSINESS ADDRESS _____

CITY _____ STATE/ZIP _____

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

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

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

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WORK PHONE (_____)_____

IF REFERRED, WHOM MAY WE THANK FOR THIS REFERRAL?

- ☐ PATIENT REFERRAL _____
- ☐ PROFESSIONAL REFERRAL_____
- ☐ OTHER _____

HIPAA 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: _____

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 Subscriber _____

INS. CO. ADDRESS_____

CITY _____ STATE & ZIP_____

SECONDARY INSURANCE COMPANY _____ PHONE # _____

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

INSURANCE ID# _____ NAME OF THE INSURED _____

POLICY GROUP #_____ Birth Date of Subscriber _____

INS. CO. ADDRESS_____

CITY _____ STATE & ZIP_____

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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:

Signed: _____

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)

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 1½% 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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