

HOPE CLINIC

A Division of Developmental Vision Associates, PLLC

* CHILD PATIENT INFORMATION (0-12 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	G	RADE 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 23rd Street
Tacoma, WA 98405-1615
(253) 925-1288

Bellevue Office
Pl. 10 Building, Ste. 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, Ste. 201
9633 Levin Road
Silverdale, WA 98383
(360) 613-0181

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DEPENDENT / RESPONSIBLE PARTY

FATHER _____	SS # _____	BIRTHDATE _____
ADDRESS _____ (If different from above)	CITY & ZIP _____	
EMPLOYER _____	WORK PHONE (____) _____	
BUSINESS ADDRESS _____	CITY _____	STATE/ZIP _____
MOTHER _____	SS # _____	BIRTHDATE _____
ADDRESS _____ (If different from above)	CITY & ZIP _____	
EMPLOYER _____	WORK PHONE (____) _____	
BUSINESS ADDRESS _____	CITY _____	STATE/ZIP _____

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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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 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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