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 G RADE or OCCUPATION

_____

_____

_____

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
Place 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 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______________________

- -

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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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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