Wendy Becker, BA, LMT, Dipl. L.Ac., EAMP, CNRT-M
2319 N. 45th St, Suite 305
Seattle, WA 98103

PATIENT CONTRACT

Date: _____/_____/_____

PATIENT INFORMATION

Name: _____Date of Birth: _____/_____/_____

Address: _____City:_____State:____Zip:_____

Primary Phone: (_____) _____ hm/mo/wk Secondary Phone: (_____) _____ hm/mo/wk

Email: _____ Employer: _____

Emergency Contact Name: _____Relation: _____

Primary Phone: (_____) _____ hm/mo/wk Secondary Phone: (_____) _____ hm/mo/wk

How did you learn about this practice and who can we thank for your referral? Doctor___ Lawyer___ Family/Friend___

Social Media___ Insurance List___ Other (please specify) _____

AUTO (PIP) or EMPLOYMENT RELATED INJURIES:

Date of Injury/Accident: _____/_____/_____ Claim Number: _____

Insurance Carrier Name: _____ Claims Adjuster Name: _____

Claims Address: _____

Adjuster's Phone Number: (_____) _____ Ext. ____ PIP/L&I Coverage limit: $_____ Amount of coverage used as of this date? $ _____ Referring Provider's Name: _____

Attorney Name: _____ Do you have other related provider's associated with this claim you are receiving treatment from? _____

HEALTH INSURANCE INFORMATION: *Please present insurance card along with doctor's prescription to be kept on file.*

Company Name: _____ Effective Date of Coverage: _____/_____/_____

Group #: _____ Identification #: _____ Copay/Coinsurance Amount: $_____

Is Patient Subscriber? Yes No If no, Subscriber's Full Name:

_____

Subscriber's SSN: _____-_____-_____ Subscriber's Date of Birth: _____/_____/_____

Subscriber's Employer: _____ Relationship to Patient: _____

Will be using a Secondary Insurance Plan, Health Savings Account or Cash?

Company Name: _____ Effective Date of Coverage: _____/_____/_____

Group #: _____ Identification #: _____ Copay/Coinsurance Amount: $_____

If yes, Subscriber's Full Name: _____

Subscriber's SSN: _____-_____-_____ Subscriber's Date of Birth: _____/_____/_____

Subscriber's Employer: _____ Relationship to Patient: _____

HSA or Cash Itemized Receipt Needed? Yes No

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PATIENT CONTRACT

PATIENT CONSENT

I GIVE PERMISSION and CONSENT TO RECEIVE therapeutic health care treatment from Wendy Becker, BA, LMP, Dipl. L.Ac., EAMP. **Please also sign separate forms:** ***Washington State Waiver* and *Acupuncture Informed Consent to Treatment & Arbitration Agreement*.** _____Initials

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Insurance reimbursement is a contract between you and your insurance company and varies by plan. It is essential that you understand your current limits and restrictions affecting your benefits for acupuncture and massage. Therefore, you will need to find out what conditions entitle you to your benefits by obtaining any necessary authorizations and referrals *prior* to your first appointment. If certain specific services, procedures, product and dietary supplements are not covered by your insurance plan, it is your responsibility to pay the difference to Wendy Becker, LMT, Dipl. L.Ac., EAMP, CNRT-M or Heal With Wendy Inc. Unless other payment arrangements have been agreed to, I AUTHORIZE treatment and AGREE to pay all fees associated with such treatment procedure(s). _____Initials

I ACKNOWLEDGE and UNDERSTAND *that using health or personal injury insurance for services rendered, is not a substitute or guaranteed payment to* Wendy Becker, LMT, Dipl. L.Ac., EAMP, CNRT-M or Heal With Wendy Inc. I AUTHORIZE my insurance benefits to be paid directly to: Heal With Wendy Inc. or Wendy Becker, BA, LMT, Dipl. L.Ac., EAMP, CNRT-M. **Preference for Invoices/Receipt Delivery:** ___In person ___Email ___Postal Service ___All delivery methods are acceptable to me. _____Initials

I AUTHORIZE RELEASE of any information required to process my insurance claim. I UNDERSTAND that if I have questions about my billing, I can contact **Medical Billing Solutions**: *Phone*: 425.292.0686 or *FAX* doctor's prescription*:* 425.292.0584
Email: kay@medbillingsolution.com _____Initials

Communications Preferences for *Appointment Scheduling*: ___Phone Call ___Text ___Email
We may leave detailed message at: Phone Number: (_____) _____ or with following person~
Individual's Name: _____ Relationship to You: _____Phone Number: (_____) _____
We may consult, share and collaborate about your specific case with mutual practitioner(s) *other than your referring provider~*
Practitioner/Colleague Name(s): _____
Phone Number: (_____) _____ _____Initials

PATIENT AGREEMENT TO FINANCIAL POLICY

Wendy Becker, LMT, Dipl. L.Ac., EAMP, CNRT-M or Heal With Wendy, Inc. will assist you in receiving reimbursement as much as is possible. However, it is your responsibility to pay for determined insurance deductible, co-payment, coinsurance, or any other balances not paid for by your insurance. I AGREE that I am *financially responsible for* all services provided and for all assessed fees including but not limited to:

- A $5.00 processing fee is applied toward all card transactions using Square. _____Initials
- An invoiced fee of $50.00 for missed appointment/late cancellation within 24 hours of your scheduled appointment will be issued to you. I am in agreement of this office policy for Wendy Becker, LMT, Dipl. L.Ac., EAMP, CNRT-M and Heal With Wendy, Inc. and understand insurance will not pay for missed appointments/late cancellations. _____Initials
- All checks returned with non-sufficient funds will be charged $20.00/week as long as payment for services remains outstanding. _____Initials
- Any collections costs, attorney fees and court costs involved with your account. _____Initials

RECEIPT of NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

You have the right to know how your healthcare information is disclosed and to request a copy of your records. It is often necessary to use and disclose this health information in order to treat you, obtain payment for our services, and to conduct healthcare operations involving our office. This information is provided in **Notice of Privacy Practices** document that can be viewed at www.healwithwendy.com or available for public review in the office. I acknowledge that I have received the Notice of Privacy Practices from Heal With Wendy Inc. _____Initials ___/___/___Date
***Annual Re-attestment*:** _____Initials ___/___/___Date; _____Initials___/___/___Date

SIGNATURE AND DATE

I have read, initialed (where required), acknowledge and understand the aforementioned policies of this **Patient Contract**.
Patient Signature: _____ Date: ____/____/____
Printed Name of Parent/Guardian: _____ Date: ____/____/____