KIRKPATRICK
FAMILY CARE

Date:_____

Patient Information:

Last Name: _____ First Name: _____ Middle Name: _____

Social Security #: _____ Date of Birth: _____ Gender: _____

Address: _____ P.O. Box_____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile Phone #: _____

Employer: _____ Work Phone #: _____

Marital Status: Married ☐ Single ☐ If you checked "Married," please fill out the following information:

Spouse's Name: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

In case of emergency, please contact the following individual: _____

Emergency Contact Phone #: _____ Relationship to Emergency Contact: _____

Insurance Coverage Information:

Do you have insurance coverage? Yes ☐ No ☐ If you checked "Yes," please fill out the following information:

Primary Insurance Company: _____ Copay Amount: _____

Policyholder Name: _____ Group #: _____ Policy #: _____

Secondary Insurance Company: _____ Copay Amount: _____

Policyholder Name: _____ Group #: _____ Policy #: _____

Financial Responsibility Agreement:

- I agree to pay my co-pay (if applicable) at the time of service.
- I authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to the provider that rendered services.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- I realize that my account may be transferred to a collection agency and my credit rating may be negatively impacted if I do not satisfy my financial responsibilities.

Please sign below to verify that the above information is correct and that you agree to the terms of the Financial Responsibility Agreement:

Signature: _____ Date: _____
(If the patient is unable to sign, the parent/guardian/power of attorney may sign here instead)

If the reason that you are seeing a provider today is to discuss an accident or injury, please answer the

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following questions:

1. Where were you when the accident or injury occurred?

   Work ☐ Home ☐ Motor Vehicle* ☐ Other: _____

2. How did the accident or injury occur (be sure to describe the physical location of the injury)?

3. On what date did the accident or injury occur?

4. Are you responsible for the payment of treatment-related services? Yes ☐ No ☐

   a. If you checked "No," who will be responsible for payment?

   Name: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone #: _____Fax #: _____

If you checked "Work" in question 1, please continue to answer questions 5-8; otherwise, you are finished filling out this form.

5. What is the name of your L&I Insurance? Self-Insured ☐ WA State L&I ☐ Other: _____

6. Have you received treatment for your accident or injury? Yes ☐ No ☐

   a. If "Yes," at what facility did you receive treatment?

   b. If "Yes," who was your health care provider?

7. Have you completed an L&I Form for this accident or injury? Yes ☐ No ☐

   a. If "Yes," have you been assigned a claim #? Yes ☐ No ☐

      i. If "Yes," what is your claim #?

8. Please provide the following information about your employer:

   Name: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Phone #: _____Fax #: _____

* *All Motor Vehicle Accident (MVA) patients will be provided information instructing them to submit all billings to the auto insurance. MVA patients will be responsible for payment of all treatment-related services.*