

PRIMAVITA FAMILY MEDICINE

Dr. Lorina Shinsato, ND, EAMP

PATIENT INFORMATION

Last Name _____ First _____ Middle _____

_____ Male _____ Female Date of Birth _____ SS# _____

Address _____ City _____

St _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____

Email _____

Employer _____

Address _____

City _____ St _____ Zip _____ Phone _____

Ext# _____

Referred by: _____

Primary Care Physician _____ Phone: _____

Current Medications: _____

Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insured subscriber _____ Relations to Insured _____

Date of birth of the Insured subscriber _____

Insurance _____ Insurance Phone# _____

ID# _____

GROUP# _____

SECONDARY INSURANCE INFORMATION

Insured subscriber _____ Relations to Insured _____

Date of birth of the Insured subscriber _____

Insurance _____ Insurance Phone# _____

ID# _____

GROUP# _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was created by the U.S. Congress to increase the privacy of individuals' personal health information. It affects all those who

are in contact with medical records or personal health information. For a detailed copy of our HIPAA practices please see "Notice of Privacy Practices".

(please initial)_____ I have received a copy of the "Notice of Privacy Practices"

(please initial)_____ I understand that if I make an appointment and do not cancel that appointment 24 hours in advance, I will be charged for that missed appointment.

I, the undersigned certify that I (or my dependent) have insurance coverage with: _____ and assign directly to Dr. Lorina Shinsato all insurance benefits, if any, otherwise payable to me for services rendered. I authorize therapy necessary for treatment and agree to pay all fees and charges for such treatment if coverage is not available. I also authorize the release of any medical or other information necessary to process insurance claims related to treatment to Dr. Lorina Shinsato's medical billing company, PUGET SOUND MEDICAL BILLING AND CONSULTING.

Signature (Parent or Guardian, if applicable)

Date