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#_____

Dr. Lorina Shinsato, ND, EAMP 15446 Bel-Red Road, Ste. B-15, Redmond, WA 98052
T:425-273-0741 / F: 866-347-2128; http://www.primavitamedicine.com

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

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