PREMIER PEDIATRICS

Natasha Wills DNP, ARNP, CPNP-PC
Pediatric Behavioral and Mental Health Services
1700 NW Gilman Blvd. Suite 205, Issaquah, WA 98027 (206) 636.1086 natasha@premierpeds.net

CLIENT INTAKE FORM

Today's Date: _____/_____/_____

Client Information

Client's Last Name	First	Middle	
Preferred Name	Birth Date	Age	Sex
Street Address	City	State	Zip Code
Social Security Number	Email	Home Phone Number ( )	
Primary Care Provider	Provider's Phone Number	Client's Cell Phone Number ( )	

Please fill out below if you are completing this form on behalf of the client:

Name	Relationship to Client	Does the client live with you? **Y / N**
Home Phone Number ( )	Cell Phone Number ( )	Work Phone Number ( )

Emergency Contact

Name of Emergency Contact		
Relationship to Client	Home Phone Number	Cell Phone Number

Primary Insurance Information (please bring your insurance care to appointments)

Insurance Company	Plan		Policy/Group Number
Name of Insured	Relationship to Client		ID Number
Insured Social Security Number	Insured Birth Date	Sex	Home Phone Number
Insured Street Address	City	State	Zip Code
Insured Occupation	Employer	Insurance Number ( )	

Secondary Insurance Information (if any)

Insurance Company	Plan	Policy/Group Number
Name of Insured	Relationship to Client	ID Number

Insured Social Security Number	Insured Birth Date	Sex	Home Phone Number

Insured Street Address	City	State	Zip Code

Insured Occupation	Employer	Insurance Number ( )

Assignment of Benefits

I hereby assign to Natasha Wills DNP, ARNP with Premier Pediatrics, PLLC my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, in my name or on my behalf. I further authorize payment of benefits directly to Natasha Wills DNP, ARNP. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by Natasha Wills DNP, ARNP. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

Client Signature: _____ **Date:** _____

Client Printed Name: _____

The authorization below is given on the client's behalf because the client is a minor or unable to sign.

Name: _____ **Relationship to Client:** _____

Signature: _____ **Date:** _____

***** For patients aged 13-18, please have both the adolescent and parent/guardian sign***

Authorization to Release Patient Health Information for Treatment, Billing or Healthcare Operations

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that Premier Pediatrics, PLLC reserves the right to change their notices and practices, and I will be given new notification if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in wiring, except to the extent that Natasha Wills DNP, ARNP and support staff have already taken action in reliance thereon. I also understand that Natasha Wills DNP, ARNP and her support staff are not required to adhere to the restrictions requested in the extent of a potentially life-threatening emergency. Records may be needed in order to process a claim for medical services. I authorize Natasha Wills DNP, ARNP with Premier Pediatrics, PLLC to release information needed for billing purposes to entities that may provide services pertaining to my provider visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may including records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.

**The patient's employer will only be contacted if necessary, in order to confirm enrollment in a healthcare plan.*

Client Signature: _____ **Date:** _____

Client Printed Name: _____

The authorization below is given on the client's behalf because the client is a minor or unable to sign.

Name: _____ **Relationship to Client:** _____

Signature: _____ **Date:** _____

***** For patients aged 13-18, please have both the adolescent and parent/guardian sign***

Acknowledgement of Receipt of Notice of Privacy Practices and Policies

In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Premier Pediatrics, PLLC Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Natasha Wills DNP, ARNP at 1700 NW Gilman Blvd. Ste. 205, Issaquah, WA 98027.

Client Signature: _____ **Date:** _____

Client Printed Name: _____

The authorization below is given on the client's behalf because the client is a minor or unable to sign.

Name: _____ **Relationship to Client:** _____

Signature: _____ **Date:** _____

***** For patients aged 13-18, please have both the adolescent and parent/guardian sign***

Acknowledgement of Receipt of Disclosure and Policy Statement

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Premier Pediatrics, PLLC's Evaluation Disclosure and Policy Statement. I understand and agree to abide by the policies and consent to receive treatment.

Client Signature: _____ **Date:** _____

Client Printed Name: _____

The authorization below is given on the client's behalf because the client is a minor or unable to sign.

Name: _____ **Relationship to Client:** _____

Signature: _____ **Date:** _____

***** For patients aged 13-18, please have both the adolescent and parent/guardian sign***