Junction Naturopathic Medicine

4302 SW Alaska St, Suite 200
Seattle, WA 98116

CONTACT INFORMATION & PAYMENT/ INSURANCE POLICY

Legal Name: Last____First______________________________MI ___________

Street Address:____Apt. # _______

City:____State:_______________Zip Code: _________________________

Mailing Address:__________________________________City:________________State:_________Zip Code: ___________

Home Phone:________________ Cell Phone: ___________ Email:____

Date of Birth:_______________________Sex: ☐ M ☐F ☐TG **SSN:** _________________________ (For insurance billing)

Job Title_______________________ Employer: _________________________ Work Phone:__________________

Marital Status: ___Single ___Married ___Separated ____Divorced ____Widowed ____Partnered

Who referred you to our office? ___________________Who is your primary care physician? _________________________

Are you looking for a Primary Care Physician? ☐ Yes ☐No

Address: _________________________ City: __________________________ Phone: ____________________________

Spouse/Partner:
Last Name:____First______________________________MI ___________

Date of Birth:_______________________Sex: ☐ M ☐ F Cell phone: ________________

Spouse/Partner's Job Title: ________________ Employer: ________________________Work Phone #______________

Emergency Contact – Someone Other Than Your Spouse/Partner:
Full Name:____Relationship ______________________________

Home Phone: _______________ Work Phone: ________________ Cell phone: ______________________

Insurance Information
Insurance company: __________________ Group # ______________ ID#______________________

Subscriber of your plan: ___________________________ Subscriber's Employer: _____________________

Relationship to Subscriber: ___________________________

PAYMENT CONTRACT: (please read, date and sign)
I acknowledge that my health insurance policy is an arrangement between my health plan and myself. I understand it is my responsibility to know and understand my insurance policy and its benefits. I agree to pay all co-pays, deductibles, co-insurance and other charges required by my policy. If I choose to personally pay for my medical services, I will pay at the time of services. I understand that, in helping me reach my optimum health, Junction Naturopathic Medicine may provide certain services, and laboratory tests that may not be covered by my insurance policy. I understand that all these charges, along with charges for supplements, are in addition to office visits and I agree to pay at the end of the appointment. I am responsible for all bills incurred through this office.

I have read and completed all the information on this sheet and certify this information to be true and correct to the best of my knowledge. I will notify the doctor of any changes in the above information. I am aware of the policies regarding payment and furthermore consent to treatment by Dr. Jeana Kimball ND, MPH or any other associate physicians in the practice.

LEGAL NAME, PRINTED: ____________________________________ **DATED AT SEATTLE, WASHINGTON, on**

DATE: ____________________________ **SIGNATURE:** __________________________________