JUNE PEDIATRIC CONSULTING

Holly Stafford DNP, ARNP, CPNP-PC
Pediatric Behavioral and Mental Health Services

1700 NW Gilman Blvd. Suite 205 Issaquah, WA 98027 ♦ (425) 657-8880 ♦ Holly@JunePC.com

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 No. — —	Email	Home Phone No. ( )	
Primary Care Provider	Provider's Phone No. ( )	Client's Cell Phone No. ( )	
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 No. ( )	Cell Phone No. ( )	Work Phone No. ( )	

Emergency Contact

Name of contact in case of emergency		
Relationship to Client	Home Phone No. ( )	Other Phone No. ( )

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

Insurance Company	Plan	Policy/Group No.	
Name of Insured	Relationship to Client	I.D.#	
Insured's Social Security No. — —	Insured's Birth Date / /	Sex	Home Phone No. ( )
Insured's Street Address	City	State	Zip Code
Insured's Occupation	Employer	Insurance Company No. ( )	

Secondary Insurance Information (if any)

Insurance Company	Plan	Policy/Group No.	
Name of Insured	Relationship to Client	I.D.#	
Insured's Social Security No. — —	Insured's Birth Date / /	Sex	Home Phone No. ( )
Insured's Street Address	City	State	Zip Code
Insured's Occupation	Employer	Insurance Company No. ( )	

Assignment of Benefits

I hereby assign to Holly Stafford, ARNP with June Pediatric Consulting, 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 Holly Stafford, 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 Holly Stafford, 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:**_____

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 June Pediatric Consulting, 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 writing, except to the extent that Holly Stafford, ARNP and support staff have already taken action in reliance thereon. I also understand that Holly Stafford, ARNP and her support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency. Records may be needed in order to process a claim for medical services. I authorize Holly Stafford, ARNP with June Pediatric Consulting, PLLC to release information needed for billing purposes to entities that may provide services pertaining to my physician 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 include 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 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 June Pediatric Consulting's Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Holly Stafford, 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 June Pediatric Consulting'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***