

# Spokane Homeopathic Clinic

2814 S. Grand Blvd.  
Spokane, WA 99203  
(509) 456-2570  
www.childhomeopathy.com

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## Patient Registration Form

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Marital status (required by insurance) \_\_\_\_\_ Spouse or parent's name (if applicable) \_\_\_\_\_

### Person responsible for charges if different from patient:

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

### Emergency Contact Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to patient \_\_\_\_\_

### Insurance information

Primary Insurance \_\_\_\_\_

Group Number \_\_\_\_\_ ID number \_\_\_\_\_

Subscriber name \_\_\_\_\_ Subscriber birth date \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Are there any physicians you would like us to keep informed of your progress? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Insurance

Health insurance is an agreement between you and your insurance company. You are responsible for contacting your insurance carrier regarding coverage for treatment. If the insurer requires a referral you must have this paperwork completed prior to the visit and we must receive a copy prior to treatment. Our office bills only insurers with whom we have a contract. For all others payment is required at time of service.

I have read the above and agree to assume responsibility for charges incurred from treatment at Children's Homeopathic Clinic. I authorize my insurance company to pay physicians at this clinic for services rendered.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

**Payment is required at time of service. Thank you.**