Craig Peterson, ND, LAc, FABNO

INTEGRATIVE ONCOLOGY

REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____

Date of Birth (required) _____ Gender ____ Other names that records may be under_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Social Security #: _____

May we leave confidential voice-mail messages for you at any of the avove numbers? ☐ Yes ☐ No

If Yes please specify. ☐ Home ☐ Work ☐ Cell

Emergency Contact Name _____ Phone # _____ Relationship _____

Insurance Information

It is recommended that you contact your insurance company to verify coverage for naturopathic physicians and services. Your policy may not cover claims made by this office.

Person Responsible for bill: _____ Relation to patient _____

Address (If different) _____ Date of Birth (required) _____ Phone _____

Employer _____ Employer address _____ Work Phone _____

Is this person covered by insurance? ☐ Yes ☐ No

Name of primary insurance _____

ID Number _____ Group Number _____ Co-payment $_____

Subscribers Name _____

Subscribers SS# _____ Date of Birth (required) _____

Patient's Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

The above information is true to the best of my knowledge. By my signature below, I _____, authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Puget Sound Integrative Oncology or my insurance company to release any information required to process my claim.

_____ _____

Signature of patient (or Guardian/Representative) **Date**

Privacy Terms

Your Provider keeps a record of the healthcare services that you are provided. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record we keep. Moreover, if you believe that information in your record is inaccurate, you may also request that we correct or amend that record. We will not disclose your medical information to others unless you direct us to do so or applicable laws authorize or compel us to do so. We are required to provide you with a copy of its Notice of Privacy Practices and to obtain written acknowledgement that you have received it. The notice outlines the types of uses and disclosures that may occur involving your protected health information describes your rights and explains how you may exercise those rights. Please read it carefully. If you have questions concerning the management of your healthcare information and wish to inquire about your rights or if you wish to schedule an appointment to view your medical record, please call the office at (206) 698-9826.

I hereby acknowledge that I have received a copy of the privacy practice for Puget Sound Integrative Oncology.

_____ _____

Signature of patient (or Guardian/Representative) **Date**