Advanced Family Wellness Inc. PS
1115 west Bay Dr. NW, Suite 202
Olympia, WA 98502
Phone: (360)570-8010 / Fax: (360)570-8009

Primary Care Provider: _____ Provider Phone #: (_____) (_____) (_____)

Ms. Mrs. Mr (Please circle one) Sex: Female Male (Please circle one)

Patient Name: _____ _____ _____

(Last) (First) (MI)

Home Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (if different from home address): _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) (_____) (_____) > > > **Can we leave a detailed message? Y / N**

Work: (_____) (_____) (_____) (ext) _____ > > > **Can we leave a detailed message? Y / N**

Cell: (_____) (_____) (_____) > > > **Can we leave a detailed message? Y / N**

Email: _____

Social Security #: (_____) (_____) (_____) Date of Birth: _____ Age: _____

(mm/dd/yy)

Patient Occupation: _____ Employer / School: _____

Employer/School Address: _____ (City): _____ (State): _____

Marital Status: (S) (M) (D) (W) (P) Other: _____

Emergency contact: _____ PH#: (_____) (_____) (_____)

Relationship to Self: _____

Name of Insurance Company: _____

Policy #: _____ Group #: _____

1. Policy Holder's Name: _____ DOB: ____ / ____ / ____

   SSN: (_____) (_____) (_____) Policy holder's place of employment: _____

2. Your relationship to policy holder: (Self/Spouse/Father/Mother/Other)

Secondary Insurance: _____

Policy #: _____ Group #: _____

1. Policy Holder's name: _____ DOB: ____ / ____ / ____

   SSN: (_____) (_____) (_____) Policy Holder's place of employment: _____

2. Your relationship to policy holder: (Self / Spouse / Father / Mother / Other)

RELEASE OF BENEFITS AND INFORMATION

I authorize my insurance benefits to be paid directly to Advanced Family Wellness Inc. Ps. I am financially responsible for any unpaid balance. I authorize Advanced Family Wellness Inc. PS. or Insurance Company to release any information required for the claim. I understand a 15% interest fee will be charged on all past due accounts. I consent to receive treatment as prescribed. I understand that fees are payable at the time services are received. I understand that Advanced Family Wellness Inc. Ps requires 3 business days advance notice for cancellation of appointments or changes in appointments. I understand that Advance Family Wellness Inc. Ps reserves the right to charge for missed appointments if sufficient notice is not given, as described above. The standard charge for missed appointment is $170.00. Advanced Family Wellness Inc., PS will forgive the first missed appointment and charge for all missed appointments thereafter.

Patient Signature: _____ Date: _____

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4. Your relationship to policy holder: (Self/Spouse/Father/Mother/Other)

Secondary Insurance: _____

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