Cori Dixon, LMP
13128 Totem Lake Blvd NE #204
Kirkland, WA 98034
425-836-6847

Registration Form

Client or Guardian Name:	Today's Date:	
Client or Guardian Birth Date:	Baby's Name, Gender & **Birth Date**:	
Street Address:	City, State, Zip:	
Cell Phone:	Home:	Work:
Occupation:	Employer:	
Email:	PCP or Pediatrician name: Phone:	
How did you hear about Cori Dixon, LMP?		
IN CASE OF EMERGENCY		
Name: Relationship: Can we leave a message with this Cell Phone: Work Phone: person? Yes or No		
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
May we call you at home? Yes No	May we leave a message at your home? Yes No	
May we leave a message on your cell? Yes No	May we call you at work? Yes No	
I acknowledge & agree to adhere to the Notice of Privacy Practices as required by federal & state guidelines. I understand I may request/review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.		
Patient/Guardian Signature:	Date:	
CONSENT FOR TREATMENT, PAYMENT AND RELEASE OF INORMATION		
I have completed this form and certify that I am the patient or legal guardian of patient. I authorize Cori Dixon, LMP to provide medical care and treatment for me. I understand that as the recipient of services, regardless of insurance reimbursement, that I am ultimately responsible for payment at time of service		
Patient/Guardian Signature:	Date:	

Updated 03/13/17 cd

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Consent for Treatment

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Phone: _____

As a patient of the Cori Dixon, LMP and by signing below:

I hereby authorize Cori Dixon, LMP to provide care, perform general procedures and treatments as necessary.

I understand that I may ask questions regarding my treatment, fees, and insurance reimbursement, or any other aspect of my care before signing this form. With this knowledge, I voluntarily consent to the policies and procedures of Cori Dixon, LMP.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during visits. I understand that free interpretive services may not be available and that I may be referred to another health care facility to provide the services necessary for my care.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice to obtain these services and that I may change my mind about receiving wellness care from Cori Dixon, LMP at any time.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by a representative or me, or otherwise permitted or required by law.

I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

_____ *Today's Date* _____

Patient Name (printed)

_____

Signature by Patient/Parent/Guardian

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Financial Contract & Office Policies

As a patient of the Cori Dixon LMP, and by signing below, I agree to the financial responsibilities for any fees and to the office policies listed below. Any fees must be paid at time of service, unless otherwise discussed and agreed upon with Cori Dixon, LMP. I also understand that it is my responsibility to confirm insurance coverage before my scheduled appointment.

Superbills: This is a cash-pay practice, meaning Cori does not accept insurance directly. Acceptable methods of payment are: all major credit cards, HAS cards, checks and cash. If you wish to submit a superbill to your insurance company for possible reimbursement, one will be provided for you. It is your responsibility to contact your insurance company directly to initiate this process. Reimbursement is dependent upon your personal plan and coverage. Please let Cori know directly if you wish to receive a superbill. All payments are due in full at time of service unless otherwise agreed upon.

Insufficient Funds Policy: If a check does not clear due to insufficient funds, a $25 fee will be added to the outstanding balance.

Late Policy: We respect your time, and we ask that you respect ours. Appointments are not double-booked and do not intentionally run over. If you are more than 10 minutes late for your appointment, you may be seen for any time remaining or asked to reschedule. If you expect to be late, please let us know as soon as possible by calling the office at 425-836-6847.

No Shows/Cancellations Policy: If you need to cancel an appointment, please do so within 24-48 business hours of the appointment time. Business hours do not include weekend or holidays. Appointments canceled with less than 24 hours notice may incur a $50 fee.

Phone & Email Consults: Brief questions can be answered over the phone or email at no charge. Complex concerns will not be answered this way; it is not good practice and can result in less optimal care. If you have a more complex concern, you will be asked to make an appointment, or you will be charged $50 for a more involved phone/email consult.

_____ _____

Name of Patient (Print) *Signature of Patient*

_____

Today's Date