Biofeedback Clinic of Edmonds, Inc., P.S.

8523 224th St. SW, Edmonds, WA 98026
(425) 672-1676
Stephanie A. Harris, RNC

Patient Name: _____ Date: _____

Address: _____ Email: _____

City _____ Sex: ____ Male ____ Female

Phone: (h) _____ Marital Status:

(w) _____ ____ Married ____ Single ____ Other

Date of Birth: _____ Student (age 19 – 23):

Social Security #: _____ ___ Full Time ___ Part Time ___ n/a

Patient's Employer or School: _____ Employed: ____ Yes ____ n/a

INSURANCE INFORMATION **Note: Payment due at time of service!**

Primary Insurance Co.: _____ Plan Name: _____

Group Number: _____ Insured's ID No.: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured's Address: _____ Phone: _____

Employer: _____ Referred by:_____

Patient's Relationship to Insured: _____ Self _____ Spouse _____ Child/Stepchild _____ Other

Secondary Insurance Co. _____ Plan Name: _____

Group Number: _____ Insured's ID No.: _____

Name of Insured: _____ Insured's Date of Birth: _____

Employer: _____

Patient's Relationship to Insured: _____ Self _____ Spouse _____ Child/Stepchild _____ Other

RESPONSIBLE PARTY INFORMATION

Name: _____ Phone: (h) _____

Address: _____ (w) _____

WHO CAN WE CONTACT IN CASE OF A CLINIC CLOSURE?

Name: _____ Phone: _____

I hereby authorize my insurance benefits to be paid directly to the provider. I realize that I am responsible to pay for any non-covered services, and that I will be liable for a monthly finance charge of 1.5% on balances over 60 days past due.
I hereby authorize the release of pertinent medical information to the insurance company.

Signed _____ Date _____

FOR OFFICE USE ONLY

Dx: _____ _____ _____ _____