Karen Coshow ND PLLC
18532 Firlands Way N, Suite C
Shoreline, WA 98133-3986
T 206.801.7784 F 206.801.7767
shorelineclinic@gmail.com

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Street Address: _____

City, State, Zip: _____

If you are using insurance, please present your card for photocopying.

Insurance Company: _____

Subscriber ID: _____ Group Number: _____

For auto or workplace injuries, date of injury: _____

List your most important health concerns:

List any medications or supplements you take regularly:

List any allergies:

Any other information you want to convey:

Privacy Policy

My privacy practices are consistent with HIPAA requirements. The document is available through my website. A hard copy is available at your request. Your information will not be shared with anyone other than required by law.

I have been notified of the Privacy Practice of Karen Coshow, ND, PLLC and have been provided an opportunity to review it.

Name: _____

Date of Birth: _____

Signature: _____ Date: _____

Financial Policy

RESPONSIBLE PARTY: You are financially responsible for paying for services that are provided to you by Karen Coshow, ND. If the patient is a child, the responsible party will be the parent and/or the assigned representative authorized to seek medical care for the child.

UNDERSTANDING YOUR BENEFITS: Please familiarize yourself with your insurance benefits. Your health plan mandates that you are financially responsible for payment of all copays, deductibles, and non-covered services; Karen Coshow,ND, PLLC is contractually obligated to collect them. We do not verify insurance benefits, which is why we highly recommend that you contact your insurance company and familiarize yourself with your policy's benefits.

UNDERSTANDING CHARGES: Patients will be charged for each service that is performed during the course of an office visit. Included in the base charge for an office visit is a discussion about the nature of the illness, an examination of the patient, medical decision making, development of a treatment plan and discussion with the patient about the plan. Other procedures are billed in addition to the charge for examination. These charges may include, but are not limited to, manual therapy, craniosacral therapy, and trigger point injections.

CO-PAYMENTS: are due at the time you check in for your appointment.

BILLING STATEMENTS: You will receive a billing statement via paypal from us after the insurance has processed your claim if there is any patient balance remaining. Your charges will be listed along with any payments received from your insurance company. This listing will correspond to the explanations of benefits you will receive from your insurance company.

REBILLING FEE: All balances are due and payable upon receipt of your statement. If your account becomes 30 days past due, a $5 rebilling fee will be added to your account and will continue to be added once every 30 days until your balance is paid in full.

PAYMENT OPTIONS: Karen Coshow ND PLLC accepts cash, checks, Visa and Mastercard.

I have read and agree to the above Karen Coshow ND PLLC financial policy. Please note that any alterations and/or notes made on this form will not be valid without prior approval and will include the signature of the authorized personnel.

_____	_____
Responsible Party Signature	Relationship to Patient
_____	_____
Responsible Party Printed Name	Date Signed