Dr Pepel Family Practice **Welcome Form Page 1**
30250 SW Parkway Ave, Ste #9, Wilsonville, OR, 97070
Phone: (503)-232-3302, Fax: (503)-200-2895
Tax ID # 20-586-7083 NPI # 1700978178

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.

Personal Information

Date_____Birth date_____SS#:_____
Patient Name_____ Driver's License_____
Male Female Transgender Minor Single Domestic Partner Married Divorced Widowed
Address_____ _____
City_____State_____Zip_____
Credit Card no:_____Exp:_____code:____zip:_____
Employer_____Occupation_____
Referred by_____

Contact Information

Home Phone_____Pharmacy Phone#_____
Work Phone_____Ext#_____
Cell Phone_____E-mail_____
Where do you prefer to receive calls? Home Work Cell Phone
When is the best time to reach you? Time Days
_____ **(your initials)** I give permission for the staff at Dr Pepel Family Practice to contact me via telephone and leave a message that may contain appointment or medical information if I am not available.
In the event of an emergency, who should we contact?
Name_____Relationship_____
Work#_____Home# _____Cell Phone#_____

Insurance Information

Primary Insurance

Name of Insured_____Relationship to patient_____
Insured's birth date_____SS#/SIN_____
Employer_____Date Employed_____
Occupation_____
Insurance Company_____Group#_____
ID# _____Insurance Address_____
Deductible_____Amount already used_____
Max. annual benefit_____

Additional Insurance **Welcome Form Page 2**

Name of Insured Relationship to patient
Insured's birth date SS#/SIN
Employer Date Employed
Occupation
Insurance Company Group#
ID# Insurance Address
Deductible Amount already used
Max. annual benefit

Responsible Party

Who is responsible for the account? Name_____
Relationship to patient _____Birth date_____
Driver's License #_____SS#/SIN_____
Address_____
City_____State_____Zip_____
Employer_____
Occupation_____Work Phone_____Ext#_____
Email_____HomePhone_____Cell_____

Authorization and Release

_____ **(Initials)** I authorize the release of any information under the HIPA Act, including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/ or other health care practitioners.

_____ **(Initials)** I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

_____ **(Initials)** I understand that the payment for all the services not covered by insurance or/and for the medicinary items is due at the time of the visit. We accept cash, checks, Am Ex, Visa, MC, and Discovery. Returned checks will be subject to a $35.00 NSF fee. Cancellations require a 24 hour notice. No show/ cancellation with less than 24 hours' notice fee $50.00

_____ **(Initials**) I understand that my insurance carrier may pay less thapn the actual bill for service. Once the insurance has determined their coverage for the services I received, I agree to be responsible for the balance according to my insurance allowed fees.

_____**Signature** of patient or parent/ guardian if minor

Consent for Treatment

I consent to receive medical care by the licensed health care professionals at Dr Pepel Family Practice. I understand that all the services rendered are services permitted under the Oregon Naturopathic Doctor License, which may include but are not limited to botanical medicine, hydrotherapy, homeopathy, nutritional supplements and counseling, injections, IV therapy, and prescription drugs included in the OR naturopathic formulary.

_____**Signature** of patient or parent/guardian if minor

_____**Date**