

**Dr Pepel Family Practice**

**Welcome Form Page 1**

**30250 SW Parkway Ave, Ste #6, 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 than 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**