GILMAN FAMILY PRACTICE (minor child Age 0 - 12)

TODAY'S DATE:	DO NOT LIST EMAIL ADDRESS FOR AGE 12 AND UNDER.

☐ BRYCE H. GILMAN, DO ☐ KRISTINA A. STEWART, PAC ☐ LAURIE DIMLER, ARNP

Patient Name: Last	First	M.I.	Gender: M F
Mailing Address:	Apt:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone: ext.	
Which Phone Number Do You Authorize our Staff to Use to leave Voicemails Containing Private Health Information?			
Patient Date of Birth:	Age:	Patient SS#:	

PATIENT RACE: ☐ CAUCASIAN ☐ AFRICAN AM ☐ ASIAN ☐ NATIVE AM ☐ OTHER_____ ☐ MORE THAN ONE ☐ REFUSE

PATIENT ETHNICITY: ☐ LATINO HISPANIC ☐ OTHER ☐ REFUSED

Emergency Contact:	Relationship to Patient:	Phone Number:

MINOR OR SPECIAL NEEDS PATIENT'S INFORMATION

Minor's Mother or Guardian Name: (Only necessary if patient is a Minor)	Minor's Father or Guardian Name: (Only necessary if patient is a Minor)
Guarantor Name: Guarantor Phone #: (Person responsible for paying the bill - Guarantor is required if the patient is a Minor)	Address: (If different than patient's address.)

☐ EMPLOYED ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ DISABLED (PATIENT EMPLOYMENT IF NOT A MINOR)

(USE GUARANTOR'S EMPLOYMENT INFORMATION FOR MINOR PATIENT OR SPECIAL NEEDS PATIENT)

Name of Employer:	Occupation:

PREFERRED PHARMACY NAME AND LOCATION

Pharmacy Name:	Pharmacy Location:

INSURANCE INFORMATION – WE MUST HAVE A COPY OF YOUR INSURANCE CARD AND PROOF OF IDENTIFICATION

Primary Insurance Co:	Secondary Insurance Co:
Group #:	Group #:
Policy ID# or Claim#	Policy ID# or Claim#
IS THE PATIENT THE SUBSCRIBER: YES ☐ NO ☐ IF NO THEN:	IS THE PATIENT THE SUBSCRIBER: YES ☐ NO ☐ IF NO THEN:
Subscriber's Name:	*Subscriber's Name:*
Subscriber's Employer:	*Subscriber's Employer:*
Subscriber's Date of Birth: / /	*Subscriber's Date of Birth:* / /
Subscriber's Relationship to Patient:	*Subscriber's Relationship to Patient:*

Release of Benefits Information

I authorize my insurance benefits to be paid directly to Drs. Gilman, Curalli and Gilman for services provided by them. I understand that the doctors' office will bill my insurance as a courtesy and that I am responsible at the time of service for all co-payments, deductibles and non-covered services. I authorize the release of information required to process my claims. (If not signed, payment is due at time of service.)

Patient/Authorized Signature:	Date: \ \
Insurance Subscriber's Signature:	Date: \ \

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Complete the Reverse side…….

PRIVACY CONSENT for MINORS under Age 12 TODAY'S DATE_____

PATIENT NAME _____DATE OF BIRTH _____ PATIENT AGE _____

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about the above named patient. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive our revised copy.

You have the right to request that we restrict how Protected Health Information about the above named patient is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you consent to our use and disclosure of Protected Health Information about the above named patient for treatment, payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you will receive our revised copy. By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on our prior consent.

I_____, give Dr. Bryce Gilman and Staff permission to use and disclose Protected Health Information related to the minor _____for treatment, payment and health care operations.
Parent/Guardian Signature_____Date_____

ADVANCED CONSENT TO TREAT MINORS

I, _____, the parent or legal guardian of my child, _____, authorize and consent to routine and emergency medical treatment for _____ when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me or when _____ no longer requires my consent for treatment.

Parent/Guardian
Signature_____Date_____

In Washington State, Minors are persons less than 18 years of age. Minors cannot consent for their own medical care with exception to the following:

- Sexually Transmitted Disease/HIV Testing (RCW 70.24.110) Minors age 14 and older may seek care for STD's; diagnostic and treatment information in confidential in this instance.
- Alcohol and Drug Treatment Outpatient and inpatient treatment of minors for chemical dependency (RWC 70.96A.095 and RCW 70.96A.097) Minors age 14 and older may give consent for himself or herself to the furnishing of outpatient treatment by a chemical dependency treatment program certified by the department. Parental authorization is required for any treatment of a minor under age 13.
- Mental Health Treatment Outpatient and Inpatient (RCW 71.34.530 and RCW 71.34.500) A minor 13 or older may be admitted for either inpatient or outpatient mental treatment without parental consent.
- Abortions/ Contraception Law provides for a minor's ability to provide consent for abortion, birth control and reproduction. There is no age limit. (See Stat v. Koome)

- Marital Status The marital status of a minor impacts the minor's ability to consent for treatment. "all minor persons married to a person of full age shall be deemed and taken to be of full age.

*If we cannot reach you for medical or billing reasons, we may verify your personal contact information by calling your emergency contact. Also, the emergency contact may be called if you have a medical emergency in our office.