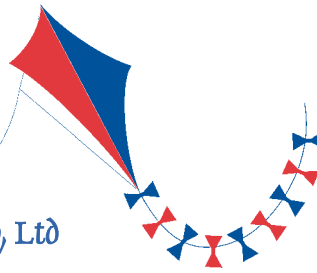


T. RAY CARDWELL, M.D.
 AGNES WONG, M.D.
 JEFFREY R. SCOTT, M.D.
 RUPIN THAKKAR, M.D.

Children's Clinic
 of South Snohomish County, Ltd



21600 Highway 99, Suite 290
 Edmonds, WA 98026
 Phone: (425) 778-0191

PERSON RESPONSIBLE FOR ACCOUNT | **CHILDREN** *(Please list all children even if not currently a patient.)*

NAME: _____
(Last) (First) (M.I.)

SSN: _____

MARITAL STATUS: Married Single Divorced Other

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____
(Street - Not P.O. Box) (P.O. Box)

(City) (State) (Zip)

HOME PHONE: _____

WORK PHONE: _____

EMPLOYER: _____

OCCUPATION: _____

NAME OF SPOUSE/OTHER: _____

SPOUSE/OTHER'S EMPLOYER: _____

OCCUPATION: _____ WORK PHONE: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME: _____
(Last) (First) (M.I.)

BIRTHDATE: ____/____/____ Male Female

NAME: _____
(Last) (First) (M.I.)

BIRTHDATE: ____/____/____ Male Female

NAME: _____
(Last) (First) (M.I.)

BIRTHDATE: ____/____/____ Male Female

NAME: _____
(Last) (First) (M.I.)

BIRTHDATE: ____/____/____ Male Female

NAME: _____
(Last) (First) (M.I.)

BIRTHDATE: ____/____/____ Male Female

PERSON TO NOTIFY IN CASE OF EMERGENCY (other than spouse):

NAME: _____ RELATIONSHIP: _____

HOME PHONE: _____ WORK PHONE: _____

CREDIT POLICY: All charges are due within 30 days from the date of service unless other arrangements have been made in advance. The parent requesting treatment for his/her child is responsible for all services rendered. If you have any questions about our policy, please contact our bookkeeper.

BILLING INFORMATION

PRIVATE PAY (NO INSURANCE)

INSURANCE (PRIMARY)

Insurance Co. _____

Policyholder _____

Social Security # _____

Subscriber's Date of Birth _____

Subscriber ID# _____

Group ID# _____ Co-Pay Amount _____

Preferred Plan Standard Plan HMO Effective Date _____

DSHS / MOLINA

INSURANCE (SECONDARY)

Insurance Co. _____

Policyholder _____

Social Security # _____

Subscriber ID# _____

Subscriber's Date of Birth _____

Group ID# _____ Co-Pay Amount _____

Preferred Plan Standard Plan HMO Effective Date _____

AUTHORIZATION TO RELEASE INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance benefits to be paid directly to the Children's Clinic for services rendered. I understand I am financially responsible for any deductible or non-covered services. I also authorize the Children's Clinic to release any information requested by the insurance company with regards to payment of benefits.

I consent to treatment for the patient's named above as deemed necessary and appropriate by the attending physician.

_____/_____/_____
 PARENT SIGNATURE (or legal guardian) | DATE