4620 Bridgeport Way W, Suite A, University Place WA 98466

(253)-368-7822 (773)-304-1911 (fax)

Thank you for planning an appointment with Fox Medical Center. Prior to your visit, we find it useful to confirm patients are aware of our financial policies as described on our website. We are a pay-at-service practice, meaning we collect our fee at the time of service, usually $150 for the basic visit, and provide you documentation to file with your insurance for reimbursement or to apply to your deductible. Please note that state insurance programs like Apple Health and Molina usually do *not* reimburse our charges. We also accept HSA/FSA accounts and we offer Care Credit financing. A blog entry on our site describes the financial benefits of using a practice such as ours.

https://foxmedical.net/blog/f/the-benefit-of-using-a-cash-based-practice

For any testing, medications, referrals, etc that are ordered by Dr Fox but performed outside our office, your regular insurance is in force and would pay whatever costs would be covered if it had been ordered by an in-network provider.

If you would like to keep your appointment, you don't need to do anything; we will be happy to see you! Prior to your appointment, you can complete the demographic and registration forms via links below at your convenience to save time, or you can complete them when you come in. If you have other questions or would like to cancel/reschedule your visit, please contact us either by replying to this email or calling our office directly at 253-368-7822.

We look forward to working with you toward good health!

Fox Medical Center – New Patient Registration

Please complete this form to the best of your ability. Some information may be required before you can be seen by a provider.

Date: ___/ ___/ ____ Preferred Language: _____

Name:_____ I prefer to be called:_____

Date of Birth: ___/ ___/ ___ SSN: _____-____-_____ Marital Status: S / M/ D/ W / DP

Gender Identity: _____ Bio Gender: M / F Preferred Pronouns: _____

Any other name that may be on your medical records? No / Yes: _____

Mailing address: _____

Phone: _____C / H / W Alternative Phone: _____C / H / W

Email: _____ Preferred method of contact? Call / text/ email

Employment Status: FT / PT/ Disabled / Self-emp / Retired / Student / Unemployed

Occupation: _____ Employer / School: _____

Emergency Contact: _____ Phone: _____
Relationship: _____

For minors, please indicate responsible parent / guardian: _____

Address and phone for above parent guardian if different than minor's : phone_____

Addr:_____

Responsible party's DOB: ___/___/ ____ SSN: ____-____-_____ Gender: F / M / Other

Employer: _____ Phone: _____

Address: _____

Financial Policy

Fox Medical Center does not accept insurance however we can provide you with documentation to help with reimbursement. We are not responsible for reimbursement or the application of your charges toward your deductible. Please be prepared to pay at time of service unless other arrangements have been made in advance. Financing of charges may be available through some commercial services. Please note if you have Medicare or state insurance, we *are* permitted to accept payment from you for services as a non-participating provider.

Do you have insurance? No / Yes.

If yes, what type? Commercial / Medicare / State Insurance / other : _____

Demographic Information:

While you are not obligated to answer these questions, understanding your ethnic and national origins may be helpful in your medical care. This information is strictly confidential.

Race:

- American Native
- Asian
- African American
- Native Hawaiian or Pacific Islander
- White
- Other identified: _____
- Decline to answer

Ethnicity:

Hispanic or Latino
Not Hispanic or Latino
Decline to Answer

Advanced Directives:

Do you have a health care proxy / living will? Y / N

If no, would you like to discuss this with your provider? Y / N

Social History:

Have you ever used tobacco: Y / N What form: smoke / chew

Currently, _____packs / cans per day / week.

I quit in _____ after using tobacco for _____years.

Do you drink alcohol: Y/ N Are you in recovery: N / Y, _____months/ yrs sober

I drink _____ regular drinks per day / week/ month. (1 beer, 1 shot of liquor or 1 glass of wine)

Do you use or previously have used any other substances? (I.e: Vape, etc) N / Y

Describe: _____

Are you in recovery from any substance use? N / Y, _____months / yrs clean

Primary Care Physician:

_____ Phone: _____

Address: _____

Preferred Pharmacy: _____ Phone: _____

Consent to treat:

I, the undersigned, voluntarily consent to and authorize Fox Medical Center (FMC) and its designated providers to provide such medical care and examinations, on a continuing basis, and to administer such routine diagnostic and/or therapeutic procedures, tests, and treatments as are considered necessary or advisable, in my diagnosis, care and treatment, in the judgment of FMC providers including, but not limited to, collecting and testing bodily fluids, and administration of pharmaceutical products. I acknowledge that no guarantees have been made to me about the results of any examination or treatment.

Acknowledgements and Agreement

- I acknowledge that I have been advised of my right to an Advance Directive.
- I acknowledge that I have read and understand the Financial Policy and agree to its terms and conditions.
- I acknowledge receipt of the Notice of Privacy Practices

Signed: _____ Date: ___/ ___/ _____