Tatyana M., MSN, ARNP, DClariT Medical & Esthetics Clinic LLC.
4317 Factoria Blvd. SE Suite C, Bellevue WA 98006 Phone: 425.444.8282 Email: tatyana@dclarity.com

PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

BIRTH DATE: _____ SEX: M F EMAIL: _____
MM/DD/YY

ADDRESS:_____
STREET ADDRESS CITY STATE ZIP

PRIMARY PHONE#:_____ ALT. PHONE#: _____

RACE: ___ American Indian/Alaska Native___ Asian___ Black/African American___ Native Hawaiian or Pacific Islander ___White ___Other Race

ETHNICITY: ____ Hispanic/Latino____ Non-Hispanic/Latino____ Declined

If other than patient:

RESPONSIBLE PARTY NAME: _____

RELATIONSHIP TO PATIENT:_____

ADDRESS:_____
STREET ADDRESS CITY STATE ZIP PHONE

How did you hear about us? □ Family
□ Friend □ Doctor □ Other:_____

EMERGENCY CONTACT:_____
LAST, FIRST RELATIONSHIP PHONE

REFERRING PHYSICIAN: _____
NAME LOCATION PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SUBSCRIBERS NAME: _____
ID#_____ GROUP#_____
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER
SECONDARY INSURANCE: _____SUBSCRIBERS NAME: _____
ID#_____ GROUP#_____
PATIENT RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

Notice of Privacy Practices-Acknowledgement

We keep a record of the health care services we provide you. You may request to see, receive and/or make corrections to that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. To request a copy of your records or for more information please call 425-444-8282. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. You may request a complete copy of our Notice of Privacy Practices.

Release of Benefits and Information

Life Time Authorization: I authorize my insurance benefits be paid directly to Tatyana Melnik, ARNP for any services furnished to me by Tatyana Melnik, ARNP DClariT Medical & Esthetics Healthcare Professional. I am responsible for any balance due along with balances due for cosmetic procedures. I authorize any holder of medical information of my own to release to my insurance company and its agents any information needed to determine benefits or the benefits payable for related services. Our office asks for a 24 hour notice to reschedule or cancel appointments. Failure to comply will result in a $50 medical visit/$75 Cosmetic visit No Show/Late Cancellation Fee. If an emergency arises, please give us as much notice as possible. By signing you are acknowledging that you have completed this form to the best of your knowledge, you have read the Notice of Privacy Practices statement; you have read the release of Benefits Information and understand our Cancellation policy.

_____ _____
PRINT PATIENT NAME PATIENT OR AUTHORIZED LEGAL SIGNATURE

_____ _____
RELATIONSHIP TO PATIENT DATE