Children's Registration Form

Gabrielle Family Vision Care 11411 NE 124th St., Bldg A, Ste 118 Kirkland, WA 98034 Ph 425.820.2143 Fax 425.820.2006
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Child's Name (LAST, First) ❑ _____ ❑ Female ❑ Male
❑ Preferred Pronouns _____

Child's Nickname Birthday (Month/Day/Year)

Street Address City State Zip

Home Phone #

Name of Guardian 1	Name of Guardian 2
Relationship to Patient/Title/Pronouns	Relationship to Patient/Title/Pronouns
Address of Guardian 1	Address of Guardian 2
Employer/Occupation of Guardian 1	Employer/Occupation of Guardian 2
Work Phone # of Guardian 1	Work Phone # of Guardian 2
Cell Phone # of Guardian 1	Cell Phone # of Guardian 2
Email of Guardian 1	Email of Guardian 2

Who does child live with? Both Guardians ❑ Guardian 1 ❑ Guardian 2 ❑ Other ❑

Who is responsible for medical decisions for child if parents are apart? Both Guardians ❑ Guardian 1 ❑ Guardian 2 ❑ Other ❑

Other family members seen in our office: _____

Who referred you to our office today?

Name: ❑ MD/ND ❑ OT ❑ PT ❑ SLP ❑ Teacher/School ❑ Friend ❑ Family

Other: ❑ Insurance ❑ Advertisement (type) _____ ❑ Web Search ❑ Other

Primary Care Physician Information:

Physician Name Phone Number

Clinic Name

Street Address City State Zip

Emergency Contact Information:

Name: Relationship: Phone #

I hereby give Gabrielle Family Vision Care permission for my evaluation and treatment. I understand that all GFVC doctors are non-contract providers for all insurance plans and the amount due for the visit is my responsibility. GFVC is non-contracted with all insurances, so GFVC declines any payment directly to the doctor/clinic for any benefits available as a non-contract provider under my insurance plan. I understand GFVC will not bill my insurance. I understand that GFVC cannot communicate with my insurance company. I understand that it is my responsibility to obtain any referrals from my PCP as outlined by my insurance policy. I understand it is my responsibility to ask for any preauthorization as outlined by my insurance policy and I understand that it is my responsibility to contact my insurance company to review benefits and eligibility and process claims and authorizations. I understand the visit fee is due BEFORE the evaluation begins. I understand there are no refunds on services or equipment and all sales are final. I understand that I am financially responsible for any non-covered charges, processing fees and charges incurred by a collection agency in collecting any unpaid balances. GFVC accepts checks (returned checks are subject to returned check charge), cash (if exact amount), Visa, MasterCard, American Express, Discover Card, and debit cards. If fees are not paid at time of service, I understand I will be charged late fees, processing fees, and collection fees. For any changes with scheduled appointments, I understand that I must call or email 48 hours BEFORE the appointment (while getting a confirmed response by the clinic) to avoid a $150 late cancel/no show charge.

Who is Financially Responsible? Name:_____Signature:_____Relation:_____

Signature of Resp. Party	Print Name of Resp Party	Date (M/D/Yr)	Child Age	Child Grade	School Name	Staff Init.	Date (M/D/Yr)