

**5130 CORPORATE CENTER COURT SE**

**LACEY, WA 98503**

**PHONE 360-413-8600**

**FAX 360-413-8822**

**Did you provide us with ALL your insurance information?**

1. Are you covered by insurance through your employer? YES NO
2. Are you insured on a plan by your parent? YES NO
3. Are you insured on a plan by your spouse? YES NO
4. Are you covered by Medicaid (Apple Health)? YES NO
5. Are you covered by Medicare Part B? YES NO
6. Are you covered by any Federal plans? YES NO
7. Are you insured by any other medical coverage? YES NO

If you answered **YES** to any of the questions above, you are required to provide our office with the billing information for that insurance before you will be seen by our providers.

You can **NOT** choose which of your insurance plans you want to use for your services. You must provide us information on all of your insurance plans and we will confirm the order in which they will need to be billed. ***This is an insurance industry requirement not a Pioneer Family Practice policy. We cannot make any exceptions to this requirement.***

Insurance plans continuously investigate their insured members to check for other health insurance. If you do not provide complete information to all of your insurance companies and to all of your providers, the insurance(s) may initially pay for services but they can take their money back months to years later when they find out you had other insurance coverage. **You will be responsible for the balance in this case.**

**Failure to disclose all of your insurance plans is considered fraud and may result in you being responsible for the entire balance of services rendered and being discharged as a patient from Pioneer Family Practice.**

I acknowledge that I have provided accurate answers to the questions above and understand that if I fail to provide complete information for all of my insurance plans that I am responsible for the balances due. I agree to immediately provide Pioneer Family Practice, with updated information if any of my insurance plans change or any of the answers to the questions above changes at any time during my care.

**Patient/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Updated: 9-14-2022