REGISTRATION FORM

DATE: ________________ ACCOUNT #: ______________

PATIENT INFORMATION

NAME: BIRTHDATE: SEX: M / F

MARITAL STATUS
Single / Married / Widow / Other

PREFERRED PHONE ☐ HOME PH: ☐ CELL PH:

STREET ADDRESS (APT #) CITY, STATE & ZIP EMAIL ADDRESS

EMPLOYER / SCHOOL PREFERRED PHARMACY:

INSURANCE INFORMATION:
(GIVE INSURANCE & PICTURE ID CARD'S TO RECEPTIONIST)

ARE YOU COVERED BY MEDICARE? ☐ YES ☐ NO INSURANCE? ☐ YES ☐ NO

SUBSCRIBER: ________________________ BIRTH DATE: ___/___/___ CO-PAY __________

EMPLOYER: ____________________ ID # _______________ GROUP # _________ HSA _________

INSURANCE CO: __________________ ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

ACCIDENT OR INJURY? ☐ YES ☐ NO DATE OF INJURY: ___/___/___

☐ WORK ☐ MVA ☐ OTHER CLAIM NO:_________________

(PLEASE FILL OUT ADD'L INJURY FORM)

CONTACT PERSON IN CASE OF EMERGENCY:______________________________

NAME ____ PHONE NO: ________________________

GOVERNMENT REQUIRED QUESTIONS:______________________________________

1. How do you identify your ethnicity?
   ___ Hispanic ___ NOT Hispanic or Latino ___ Other ___ I prefer not to answer
2. How do you identify your race?
   ___ American Indian or Alaska Native ___ Asian ___ Black or African American
   ___ Native Hawaiian or other Pacific Islander ___ Other ___ White or Caucasian
   ___ I prefer not to answer

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance.

____ ______________

SIGNATURE DATE

HEALTH QUESTIONNAIRE

Name: ______________________________ Date: _______________________

Birth date: _______________ Age: ________ Phone#_____________________

Reason for visit: ____

Medication Allergies: ____

Medications: ____

____

Personal Medical History: (Previous illnesses, injuries, surgeries or hospitalization dates).

____

____

Family Medical History: (List who has or has had the following; i.e. Mom, Dad, Sibling, Paternal or Maternal Grandmother/Grandfather, etc.)

Cancer (Type)____
Diabetes ____
High Blood Pressure ____________________________________
Heart Disease____
Stroke ____
Cholesterol ____
Alzheimer's ____
Osteoporosis ____
Alcohol/Drug Abuse ____________________________________
Other ____

Social:
Occupation: ____
Who lives in your household (adults/kids): ____________________________
What kind of Exercise do you do: ___________________________________?
Are you on a diet: ____?

Smoking:	Yes _______	Quit _________	Never __________
	Packs per Day: _____	Number of Years: _____	Years Quit: _____
	Pipe ______	Cigar ______	Chew ______

Alcohol Use: Never ____ Occ. _____ Mod. _____ Heavy ______

Alcohol Problem: Yes ______ No ______ Recreational Drugs: Yes _____ No _____

EASTSIDE
FAMILY MEDICINE
CLINIC

Office & Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat you. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. **There is a charge of $50 for cancellations without 24 hour notice and/or A missed appointments. A fee of $75 for routine exams or procedures.**
2) If you are late for your appointment (>20 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

Initial: __________

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan. There are hundreds of insurance carriers and plans. They can and do change, often yearly and in some instances more frequently. We do not have access to all of this information.
4) It is your responsibility to know if authorization is required prior to a procedure and what services are covered. You will be billed for any non-covered benefit services.

Initial: __________

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued.

Initial: ___________

Financial Responsibility

1) In accordance with your insurance plan, you are responsible for any applicable co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service. A **$20 service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
3) Patients that are self-pay, private pay or have motor vehicle insurance that we are not participating with will be expected to pay for services in FULL at the time of the visit.
4) We make every effort to get your claims paid in a timely manner; it is your responsibility to respond to any request promptly from your insurance company.

5) Any dispute with how a claim is processed is between you and your insurance company, unless it is a clinic miscalculation.
6) Patient balances are billed monthly following receipt of your insurance plan's explanation of benefits. Your payment is due within **10** business days of your bill.
7) Any account balance outstanding longer than 30 days from their first statement will be charged a **$7.50 re-billing fee** for each 30-day cycle. Any balance outstanding longer than 90 days may be forwarded to a collection agency
8) Prior to scheduling appointments, outstanding balances must be paid
9) We accept cash, checks, Visa, MasterCard credit and debit cards.
10) A $35 fee will be charged for any checks returned for insufficient funds.
11) Payments can be made through our patient portal or payment arrangements through billing.

Initial: ___________

Forms/Letters

1) There is no charge for a school, sport, or disability form given at the time of your appointment; this is considered part of the visit. **However,** should you lose or forget to bring your forms; there will be a $5 charge to replace or fill out.
2) All additional forms are subject to a $10-per-form fee. Payment is due when the forms are dropped off. We require 3-day turnaround time.
3) Letters, the fee is $35. Prior authorizations for prescriptions are done as a courtesy for our patients. However, should your insurance company deny coverage and you want your provider to write an appeal letter that fee is also $35.

Initial: _____________

Transfer of Records

1) If you wish to transfer care to another clinic, we will provide a copy of your chart as courtesy to them.
2) A copy of your complete chart is available to you on a thumb drive for a fee of $20.
3) All medical records request are done on a weekly basis, if you need them sooner please discuss with the office.

Initial: _____________

Prescription Refills

1) For medication refills, we require 72 hours notice, during regular business hours. Please plan accordingly. It is actually faster if you contact your pharmacy and request a refill than it is to call the office.

Initial: _____________

I have read and understand this policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)___________________________________Date of Birth _____________________
(please print)

Patient Signature__________________________________Date______________Acct# __________

Other Minor children on acct: ____

Responsible Party if a minor_______________________________ Date: _____________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Eastside Family Medicine Clinic respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of Eastside Family Medicine Clinic. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Office Manager – 425-453-1039

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our **[office/medical records department]** to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Office Manager – 425-453-1039

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Office Manager at **Eastside Family Medicine Clinic.** You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,
  - Accounting, legal, risk management, and insurance services; and
  - Audit functions, including fraud and abuse detection and compliance programs

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.

- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.
- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: www.eastsidefamilymedicine.com.

7. Effective date

This Notice is effective as of June 18, 2013.

Notice of Privacy Practices Acknowledgment:

Eastside Family Medicine has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, you may contact the Office Manager at **425-453-1039** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have reviewed the Notice of Privacy Practices of Eastside Family Medicine Clinic.

____

Printed name of patient

____

Patient or legally authorized individual's signature Date Time

____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

Authorization to Leave Personal Health Info by Alternative Means:

Print patient name: ______________________________ Date of Birth: ______________

Address: ____

Okay to leave detailed message: Please understand that detailed messages could include personal health information.

Home/Cell/Work (circle one): ______________________________

Or

Home/Cell/Work (circle one): ______________________________

Okay to leave message with: ______________________________ Relation: ______________

Do you want to be contacted through our secure patient portal?

(Circle one) Yes / No Are you registered? Yes / No

Don't leave detailed message for me by phone or secure message. ☐

I acknowledge and understand that this information will be kept in my medical record until revoked by me in writing. It is my responsibility to notify Eastside Family Medicine Clinic should I need to make any changes to this form.

Signature: ______________________________ Date: ______________________

This form will be retained in your medical record

March 2015