

# Edmonds Family Care

21906 76<sup>th</sup> Ave W

Edmonds, WA 98026

## Patient Information Form

|  |   |
|--|---|
| <b>Patient Information</b>   |   |
| Name (Last, First): _____  |   |
| Date of Birth: _____   | Social Security #: _____ Race: _____  |
| Street Address: _____  |   |
| City, State, _____   | Zip: _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Home Phone: _____  | Work Phone: _____   |
| Marital Status: Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> |   |
| Employer's Name or School Name: _____  |   |
| Occupation _____   |   |
| <b>Health Insurance Information (Primary)</b>  |   |
| Health Insurance Name: _____   |   |
| Address: _____   |   |
| ID#: _____   | Group #: _____  |
| Plan Name or #: _____  |   |
| Name of Insured: _____   |   |
| Birth Date: _____  | Social Security #: _____  |
| Insured's Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>                         |   |
| <b>Health Insurance Information (Secondary)</b>  |   |
| Health Insurance Name: _____   |   |
| Address: _____   |   |
| ID#: _____   | Group #: _____  |
| Plan Name or #: _____  |   |
| Name of Insured: _____   |   |
| Birth Date: _____  | Social Security #: _____  |
| Insured's Relationship to Patient: Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>                         |   |
| <b>Emergency Contact Name</b> _____  |   |
| Relationship _____   |   |
| Home Phone _____   | Work Phone _____  |
| <b>Pharmacy Name</b> _____   | Phone _____   |
| To best of my knowledge, the above information is complete and correct.  |   |
| Signature of Patient, Parent, Guardian _____   |   |
| Name _____   | Date _____  |

**Edmonds Family Care**  
**21906 76<sup>th</sup> Ave W**  
**Edmonds, WA 98026**

**Authorization for Release of Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First MI

I hereby authorization and request you to release a copy of my medical records

|                                 |                         |
|---------------------------------|-------------------------|
| To:                             | From:                   |
| Edmonds Family Care             | Dr/Office Name _____    |
| 21906 76 <sup>th</sup> AVE West | Address _____           |
| Edmonds, WA 98026               | City/State/Zip _____    |
| Ph(425)775-2066                 | Phone# _____ Fax# _____ |
| Fax (425)275-9820               |                         |

Purpose for Release of Information of Records: Transfer of Care \_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ All health of information in my medical record  
\_\_\_\_\_ Specific records related to the following condition: \_\_\_\_\_  
\_\_\_\_\_ Specifically excluded \_\_\_\_\_

I hereby authorize Edmonds Family Care Clinic to release any medical information as requested above. This may include information about any tests/treatments relating to the sexually transmitted disease, HIV, mental health, drug and/or alcohol abuse, and/or illness, social work, or other protected information unless otherwise excluded.

Information will not be released without a valid signature below. This authorization is good for 90 days from the signature date and maybe revoked in writing at any time provided the information has not yet released.

Patient or Legal authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship (patient, parent, guardian, etc) \_\_\_\_\_

Edmonds Family Care  
21906 76<sup>th</sup> Ave West  
Edmonds, WA 98026  
425-775-2066

According Edmonds Family Care policy our physicians do not provide chronic pain management with medications such as: methadone, morphine, vicodin, percocet and other.

I agree and understand.

Patient Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

## HIPAA NOTICE of PRIVACY PRACTICES

Effective Date 09.01.2005

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with copy of this notice which describes the health information privacy practices of our office, its employed medical staff and affiliated health care providers that jointly perform payment activities and business operations with our office. "Protected Health Information" is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Patient's Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### IMPORTANT SUMMARY INFORMATION.

**Requirement for Written Authorization.** We will generally obtain your written authorization before using your health information or sharing it with others outside the office. You may also initiate a transfer of your records to another person by completing an authorization form. If you provide us with written authorization, you may revoke that authorization at any time, except to the extent that we have already relied upon it. To revoke an authorization, please write to Edmonds Family Care, 21906 76th Ave West, Edmonds, WA 98026. Tel: 425-775-2066

**Exceptions To Requirement.** There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

▪ **Exception For Treatment, Payment and Healthcare Operation.** We will only obtain your general consent one time to use and disclose your health information to treat your condition, collect payment for that treatment, or run our office's normal business operations.

▪ **Exception For Facility Directory And Disclosure To Friends And Family Involved In your Care.** We will ask you whether you have an objection to including information about you in our Office Directory or sharing information about your health with your friends and family involved in your care.

▪ **Exception In Emergencies Or Public Need.** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at New York State or City Health Departments who are authorized to investigate and control the spread of diseases.

▪ **Exception If Information Does Not Identify You.** We may use or disclose your health information if we have removed any information that might reveal who you are.

**How To Access Your Health Information.** You generally have the right to inspect and copy your health information.

**How To Request Additional Privacy Protection.** You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to your request, but if we do, we will be bound by our agreement.

**How To Request More Confidential Communications.** You have the right to request that we contact you in a way that is more confidential for you, such as at work instead of at home. We will try to accommodate all reasonable requests.

**How To Correct Your Health Information.** You have the right to request that we amend your health information if you believe it is inaccurate or incomplete.

**How To Keep Track Of The Ways Your Health Information Has Been Shared With Others.** You have the right receive a list from us, called an "accounting list", which provides information about when and how we have disclosed your health information to outside persons or organizations. Many routine disclosures we make will not be included on this list, but the list will identify non-routine disclosures of your information.

**How Someone May Act On Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

**How To Learn About Special Protections For HIV, Alcohol and Substance Abuse, Mental Health And Genetic Information.** Special privacy protections apply to HIV-related information, alcohol and substance abuse information, mental health information and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected.

**How To Obtain A Copy Of This Notice.** You have the right to a paper copy of this notice. You may request a paper copy at any time, even if you have previously agreed to receive this notice electronically. Given any change in our Privacy Practices from time to time, we will revise this Notice so you will have an accurate summary of our practices. We will post any revised notice in our office reception area.

**How To File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us or with or with the Secretary of the Department of Health and Human Services. No one will retaliate or take action against you for filing a complaint.

**Edmonds Family Care, 21906 76<sup>th</sup> Ave West, Edmonds, WA 98026. Tel: 425-775-2066**

**OFFICE USE ONLY:** I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices, but unable to do so as documented below: Reason:                      Signature                      Data

## Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you on request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your Insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patient can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some—and perhaps all—of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay, for these services in full at the time of Visit.
4. **Proof of Insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your Insurance Company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your Insurance Company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge \$25 for missed appointments not canceled within a 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party \_\_\_\_\_

Date \_\_\_\_\_

EDMONDS FAMILY CARE  
21906 76<sup>th</sup> Ave West. Edmonds WA 98026

1. Tell us **about your self**:

Married \_\_\_ Single \_\_\_ Widowed \_\_\_ How many kids you have? \_\_\_\_\_

2. What are / were the **major medical problems** in your

Father \_\_\_\_\_ alive \_\_\_ deceased \_\_\_\_\_

Mother \_\_\_\_\_ alive \_\_\_ deceased \_\_\_\_\_

Brother(s), Sister(s) \_\_\_\_\_

2. Do you **smoke**? Yes \_\_\_ No \_\_\_

How many pack a day \_\_\_\_\_ How many years \_\_\_ I stopped \_\_\_\_\_ years ago

3. **Alcohol** : Occasionally \_\_\_ Heavy \_\_\_ None \_\_\_

4. **Illicit Drugs**: Yes \_\_\_ No \_\_\_ **Occupation** \_\_\_\_\_

5. List all **Allergies** to medications/substances: \_\_\_\_\_

6. What **Medications and dosage** do you currently take

1 \_\_\_\_\_ 2 \_\_\_\_\_

3 \_\_\_\_\_ 4 \_\_\_\_\_

5 \_\_\_\_\_ 6 \_\_\_\_\_

7 \_\_\_\_\_ 7 \_\_\_\_\_

8 \_\_\_\_\_ 9 \_\_\_\_\_

10 \_\_\_\_\_ 11 \_\_\_\_\_

7. Tell us about your **Past Medical History**.

**Medical Problems:**

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

**Surgeries:**

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

8. **(Female only)** Last Pap Smear date \_\_\_\_\_

Last Mammogram date \_\_\_\_\_