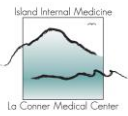


IIM/LCMC PROSPECTIVE PATIENTS

PLEASE DO NOT LEAVE FIELDS BLANK

Date

Legal First Name | Middle Initial | Last Name | Birthdate

Street and Apt # | City | State | Zip Code

Primary Telephone | Alternate Telephone | *Previous/Referring* Provider

Social Security Number | Employer | Employer Phone # | Provider you wish to establish with

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Dependent
- ☐ Widow

Race
- ☐ White/Caucasian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Prefer Not to Disclose
- ☐ Other______________________

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer Not to Disclose

Gender
- ☐ Male
- ☐ Female
- ☐ Transgender

Would you like access to our **patient portal** and to receive lab notifications on-line?
- ☐ Yes
- ☐ No

If yes, please provide your email address

Pharmacy Name | City and State

Emergency Contact Full Name | Relationship | Phone #

Parent/Spouse/Partner Full Name | Relationship | Phone # | Employer

BILLING INFORMATION

PRIMARY INSURANCE	
Insurance Company	
Subscriber Name	
Birthdate	
Group #	
ID #	
Subscriber's Employer	

SECONDARY INSURANCE	
Insurance Company	
Subscriber Name	
Birthdate	
Group #	
ID #	
Subscriber's Employer	

BILLING CONTACT | Complete *only if* the person responsible for the bill is *not the patient*.

First Name | Middle Initial | Last Name | Relationship

Street and Apt # | City | State | Zip Code

Primary Telephone | Employer | Employer Phone #

Employer Address

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance to be paid directly to my provider. I also authorize my provider or insurance company to release any information for processing my claims.

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date

HEALTH HISTORY

Legal First Name	Middle Initial	Last Name	Birthdate

MEDICATION LIST				
Start Date & End Date	**Name of Medication** (Prescriptions, Over-the-Counter, and Supplements)	**Strength** (e.g. the number of mg per pill)	**Dosage** (How many pills or mg do you take at a time?)	**Frequency** (How often do you take that dose? E.g. once a day, twice a day, as needed, etc.)

I acknowledge that I have listed ALL medications, including medications for chronic pain.

________*(initial)*

ALLERGIES & SENSITIVITIES – please list below the medication & side effect

Date of Last Physical Exam

TETANUS BOOSTER
Yes Date:________
No No

PNEUMONIA SHOT
Yes Date:________
No No

ADVANCED DIRECTIVE or LIVING WILL?
Yes Yes
No No

List medical problems that other doctors have diagnosed	
1.	
2.	
3.	
4.	
5.	
6.	

List surgeries, hospitalizations, major injuries & dates if known	
1.	
2.	
3.	
4.	
5.	
6.	

Children	
Age	Gender

Family Health History			
Family Member	Age *if Alive*	Age *at Death*	Significant Health Problems
Mother			
Father			
Siblings			
Siblings			
Siblings			

HEALTH HISTORY CONTINUED….

Legal First Name	Middle Initial	Last Name	Birthdate

Women Only	
Onset of Menstruation	
Last Menstrual Period	
Last Colonoscopy	
Date of Last Pap Smear	
Date of Last Mammogram	
History of Abnormalities:	
# Pregnancies	
# Live Births	
# C-Sections	
Did you have a hysterectomy?	

Men Only	
Last Prostate Exam	
Last Rectal Exam	
Last Colonoscopy	
History of Abnormalities:	

Diseases	List Relatives Affected
Cancer / What Kind?	
Diabetes	
Stroke	
Heart Disease	
Heart Attack	
High Blood Pressure	
High Cholesterol	
Osteoporosis	
Depression	

ALCOHOL

Yes	# drinks/week:_____
No	None

TOBACCO

Yes	Quit date:_______
No	Never

CIGARS/PIPES/CHEW

Yes	#/day:______
No	# years:______

CAFFEINE

Yes	# cups/day:_____
No	None

CIGARETTES

Yes	Packs/day:_____
No	None

EXERCISE

Yes	Days/week:___
No	Never

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct 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. You may see your record or get more information about it by contacting our Administration team at Island Internal Medicine, Inc., PS

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.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date

IIM/LCMC PROSPECTIVE PATIENTS

CONSENT FORM

I understand that my healthcare information at Island Internal Medicine/La Conner Medical Center (IIM) is protected and I have received a copy of their Notice of Privacy Practices. In order for IIM to leave detailed messages on my voicemail or answering machine, I need to give permission to IIM to do so.

Consent for Leaving Messages

By signing below, I consent to information regarding my or my child's (under the age of 18) lab test results or appointment reminders/instructions be left on my voicemail or answering machines. I understand that "sensitive" information as noted below will be excluded.

IF NOT,
INITIAL HERE → *I **do not** give consent for IIM to leave messages* ________ initials

Consent for Shared Information with Family & Friends

By signing below, I wish family members or friends to have access to my healthcare information. The name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the judgment of my provider or his/her designee to release any "sensitive" information. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

Family/Friend Name	Relationship	Phone #

I understand that some information is "sensitive". I understand that **I must check** the specific boxes in order for my provider or his/her designee to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ HIV/AIDS Virus
- ☐ Sexually Transmitted Diseases
- ☐ Pregnancy Information

IF NOT,
INITIAL HERE → *I **do not** give consent for IIM to share information with family/friends* ________ initials

Patient Name (PRINT)	Date of Birth

Signature of Applicant	Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

RELEASE RECORDS FROM	SEND RECORDS TO
Name of Organization	Name of Organization
Mailing Address	Mailing Address
City / State / Zip	City / State / Zip
Telephone / Fax	Telephone / Fax

Reason For Request

I request that my medical records be released to the person(s) or Institution named above.

SPECIFICALLY **EXCLUDE**:____

SPECIFICALLY INCLUDE:

- [ ] Labs
- [ ] Medical Records Last 2 Years Only
- [ ] X-Ray Reports
- [ ] Most Recent Physical
- [ ] Other: ____

I understand that my express consent is required to release information relating to sexually transmitted disease including HIV/AIDS, mental illness and/or drug or alcohol abuse. If I have been tested, treated or diagnosed in connection with any sexually transmitted disease including HIV/AIDS, drug or alcohol abuse, and/or mental illness, you are specifically authorized to release to the person(s) or institution named above all information or medical records relating to such diagnosis, testing or treatment unless specifically excluded below. The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written Authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general Authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

I understand that the subsequent use or release of this medical information cannot be limited or controlled by the person(s) or institution releasing these records. This request is a free and voluntary act by me. I hereby release all legal responsibility that may arise from the release of the medical information as authorized by me. Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. I may revoke this Authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic **expiration date** of this Authorization will be **90 days** from the date of the signature. **By signing this page, I acknowledge that I have read and agree to the terms on this page.**

Patient Name	Date of Birth	Social Security Number

Signature of Applicant	Date

LATE CANCELLATION/NO SHOW FEES:

We appreciate our patients being prompt and being in attendance at their scheduled appointments. *New patients* who miss their first appointment will not be rescheduled with the practice. Cancellations must be made by phone and will not be accepted over the patient portal.

Definitions and Fees:

- *Late Cancellation* – cancellation without sufficient notice of 24 hours (2 business days). The fee for a 'late cancellation' is $40 per visit.
- *No Show* – patient does not show up for appointment and does not notify by phone that they are not able to make it for their scheduled appointment. The fee for a 'no show' is $40 per visit.
- $100 per visit will be charged for a missed physical examination whether it's a late cancellation or no show.

MEDICATION/PRESCRIPTION REFILL REQUIREMENTS:

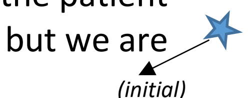
We require **72 hours** (3 business days) notice to process refill requests. Please do not call from the pharmacy and expect an immediate refill while you wait. All attempts should be made to refill your ongoing prescriptions at your appointment time.

If you should run out of an ongoing prescription in between appointments, we ask that you **call your pharmacy** and they will fax a refill request to our office; even if you do not have refills remaining. Plan ahead so you have a few pills left before you call for refills. If you missed an appointment, you will be asked to come in to see your healthcare provider before any refills are given.

If you are on chronic medications, you will need to be checked by your provider on a periodic basis. No refills will be given to any patient who has not been in to see their provider in the last year, or as advised. Requests for prescriptions for medical problems for which you have not been previously seen, e.g. pain pills or antibiotics, are discouraged. **All narcotic prescription (e.g. pain medication) refills must be done at the time of your office visit.**

PATIENT PORTAL

Please allow for 72 hours (3 business days) for a return on messages you send through the patient portal. Please do not send urgent requests/inquiries through the patient portal. Not all of your medical records are available on the patient portal but we are able to send you a copy of documents if you request it.



_______*(initial)*

CO-PAYMENTS

Co-payments are required at the time of your service. You will be charged an additional $20.00 administrative fee if you do not pay your co-pay at the time of service. These payments are part of your contract with your insurance company that require you to pay at the time of service with your provider. You may pay these with cash, credit card or check. The amount of co-payment is usually printed on your insurance card. If it is not, please call your insurance company.

BILLING

We make every effort to file the appropriate code(s) encountered and documented in your medical record. Our office is given Service Codes and guidelines to follow to prevent inappropriate charges being billed to you and your insurance company. We are unable to bill for services other than those documented in your medical record. We cannot code or charge based on your insurance coverage. We cannot change a code after a visit, as this can be construed as fraud by the insurance company or Medicare.

As a courtesy, this clinic will file a claim with the primary insurance on your behalf. All charges, regardless of the insurance coverage, are your responsibility. If your insurance has not paid within 45 days, we ask that you follow-up with them. Any questions regarding your benefits and coverage need to be directed to the insurance company prior to your appointment.

If you are private/self-paying, we offer a 20% discount for if you pay in full on the day of service. If you do not have insurance, payment is expected when services are rendered.

By signing below, I acknowledge receipt of the Notice of Clinic Policies.

Patient Name (PRINT)	Date of Birth
Signature of Applicant	Date