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

IIM/LCMC PROSPECTIVE PATIENTS

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 <u>medications for chronic pain</u>.

_____*(initial)*

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

Date of Last Physical Exam	TETANUS BOOSTER	PNEUMONIA SHOT	ADVANCED DIRECTIVE or LIVING WILL?
	Yes Date:_____ No No	Yes Date:_____ No No	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

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 #
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.

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.

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. You have the right to revoke or cancel this authorization, in writing, at any time.

SPECIFICALLY EXCLUDE:_____

SPECIFICALLY INCLUDE:

- ☐ Medical Records (Any and All)
- ☐ Medical Records (Last 2 Years Only)
- ☐ Most Recent Physical
- ☐ Labs/Pathology
- ☐ Radiology Reports
- ☐ Colonoscopy Reports
- ☐ Operative Reports
- ☐ Other:_____

Patient Name | Date of Birth | Social Security Number

Signature of Applicant | Date

LATE CANCELLATION/NO SHOW FEES:

We greatly appreciate our patients being prompt to their scheduled appointments. However, *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 24 hours (2 business days) prior notice. The fee for a 'late cancellation' is $40 per visit.
- *No Show* – patient does not show up 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. Ideally, refills of your ongoing prescriptions are done at the time of your visit.

If you should run out of a prescription in between visits, we ask that you first contact **your pharmacy** and they will fax a refill request to our office. If you have missed an appointment, you might be asked to come in to see your healthcare provider before any refills are given.

Requests for prescriptions for medical problems for which you have not been previously seen, e.g. pain pills or antibiotics, are discouraged. **All narcotic prescriptions (e.g. pain medication) refills are only done at the time of your office visit.**

PATIENT PORTAL

Please allow up to 72 hours (3 business days) for a return on messages on the patient portal. Please do not send urgent messages through the patient portal.

_____*(initial)*

CO-PAYMENTS

Co-payments are due at the time of service. Your account may be assessed a $20.00 administrative fee for failure to pay at time of service. These payments are part of your contracted benefits with your insurance company. We are happy to accept your payment in the form of cash, credit card, or check.

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 change a code after a visit, as this can be construed as fraud by the insurance company or Medicare.

As a courtesy, IIM/LCMC will file a claim with your primary insurance on your behalf. Any questions regarding your benefits and coverage should be directed to your insurance carrier. Our goal at Island Internal Medicine/ La Conner Medical Center is to ensure your clinic bill is processed correctly and in a timely manner. Please make sure you notify us of any changes to your insurance coverage.

If you are self-pay/noninsured; payment for your visit is due at time of service.

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

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