TouchStone
HEALTH CLINIC
Where healing begins

# Primary Care NEW Patient Packets

Welcome to Touchstone Health Clinic, where healing begins.

For your first appointment, please complete this packet and provide insurance card and photo ID.

** Please note that a parent/guardian must sign consent forms for children age 12 and under. Children age 13 and over must sign their own consent forms. **

288 Martin St., Ste 100, Blaine, WA 98230 & 6046 Portal Way, Ste 104, Ferndale, WA 98248
Phone: 360-788-4228 Fax: 360-778-1423 - www.touchstonebhc.com

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## Patient's Health Information

**Today's Date: _____**

**A) Patient Information**

Patient Name: _____ Male Female (circle)

Date of Birth: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone: Cell) _____ Home) _____Work) _____

I authorize Touchstone Health Clinic to leave health related information via the following options?

(Circle): Phone: Cell / Home / Work Email or DO NOT CONTACT

I authorize Touchstone to send me call reminders via (Circle): Text / Email / Call Home

Married (circle): YES / NO Divorced (circle): YES / NO Other _____

Employer: _____ Occupation: _____

Work Related Injury (circle) : YES / NO If Yes, Date of Injury: _____

Preferred Language: _____ Do you need a translator? YES / NO

Ethnicity: (Check One): _____Hispanic, _____Non-Hispanic, _____Unknown and/or No Disclosure

Race (Check One): _____ White, _____ African American. _____ Native American/Eskimo/Aleut,

_____ Asian/Pacific Islander, _____ Other, _____ Unknown

How did you hear about us?: _____

_____

**Emergency Contact**

Name: _____ Relationship: _____ Phone: _____

Secondary Phone: _____ Email: _____

**Primary Health Care Provider**

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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**Advanced Directives**

Do you have an advanced directive? YES / NO If YES, when was it last reviewed?: _____

If YES, does it include any of the following (circle all that apply)?

Do Not Resuscitate Medical Power of Attorney Living Will

**B) Health Insurance Information**

Primary Health Insurance Company: _____

Insurance Address: _____

Insurance Provider Phone Number: _____

Group ID # : _____ Patient ID # _____

Policy holder (if other than self): _____ DOB: _____

Do you have secondary Insurance? YES / NO If YES, Please provide the following information:

Secondary Insurance Company: _____

Insurance Address: _____

Insurance Provider Phone Number: _____

Group #: _____ Patient ID #: _____

Policy holder (if other than self): _____ DOB: _____

To better help you with financial services please provide the following additional information:

Family Size _____ Total Family Household Income: _____

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**C) Current Health Information**

Top Three Health Concerns or Topics you would like to discuss with your provider:

1. _____
2. _____
3. _____

Check the following severity of the health concerns: ____ Mild, ____ Moderate, ____ Disabling,
___ Constant, ____ Intermittent, ____ Getting Worse, ____ Getting Better, ____ No Change

Have you received any treatment for the health concerns?: ___ YES ___ NO
If YES where?: _____; with whom: _____

Please list ALL Medications, Over the Counter Medications, Herbal Remedies & Supplements you are taking:

_____
_____
_____
_____
_____

Have your medications changed in the past 3 months? ___ YES ___ NO
Have your medications been reviewed in the last 3 months? ___ YES ___ NO
Please list ALL Allergies (Including Environmental, Food and Medication): _____
_____
_____

Substance Use:

Do you Smoke Tobacco? YES / NO E-Cigs?: YES / NO Marijuana?: YES / NO
Chewing Tobacco?: YES / NO Other? _____
If YES, how long have you smoked?: _____ (years) How many packs: _____ per (circle) day / week?
Have you been offered smoking cessation materials?: YES / NO
Do you take recreational drugs?: YES / NO If YES, please list: _____
Do you drink alcohol? YES / NO If YES, how many per day _____ wk.: _____
Do you drink coffee/caffeinated beverages? YES / NO How many per day: _____ wk.: _____

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**D) Health History**

List & Explain any for the following, and include dates and treatment received:

Surgeries: _____

Accidents: _____

Major Illness: _____

Date of last (if applicable): Physical/annual Exam: _____ Blood Tests: _____

Mammogram: _____ Pap: _____ Colonoscopy: _____

**Sexual Health:** (Check one) ____ Not Sexually Active ____ Sexually Active _____ Not Yet Had Sex

If active: How many people have you had sex with in the last year? _____

Have you had sex with someone new in the last 90 days? ____ YES ____ NO

Do you have sex with (Check one): ___ Men, ___ Women, ___ Both

Do the person(s) you have sex with have sex with (Check all that apply): ____ Men, ____ Women, ____ Unknown

Does the person(s) you have sex with only have sex with you? ___ YES ___ NO ___ Unknown

Is your sexual contact (Check all that apply): ___ Vaginal , ____ Oral , ____ Anal , Other:_____

Do you use condoms? ____ Always ____ Sometimes ____ Never

Have you been exposed to a Sexually Transmitted Infection (STI) recently? ____ NO ___ YES

Has the person(s) you have sex with had any STI symptoms in the last 60 days? ___ YES ___ NO ___ Unknown

Have you ever shared needles (tattoo, IV drug use, etc.)? ___ NO ___ YES

Have you had sex with someone who uses IV drugs? ___ NO ___ YES ___ Unknown

Did you get a blood transfusion before 1985? ___ NO ___ YES

**Contraceptive/Menstrual History/Pregnancy:**

Do you current use birth control? ___ YES ___ NO If YES, what method(s) and Have you had any problems with your birth control method(s)? _____

_____

Menstrual Cycles: Please select all of the following that apply (skip if they do not apply)

Age when period started: _____, Currently you: ____ Have cycles, ____ Going through menopause

____ On birth control that stops cycles _____ Post menopause Other:_____

If you have cycles, are they: ____ regular, _____ irregular (every month is different)

Periods last ____ days. Bleeding is ____ light ____ moderate ___ heavy

Have you ever been pregnant? ___ YES ___ NO If NO, skip to next section.

Number of: Pregnancies _____, Births ____ , Miscarriages ____, Abortions ____,

Ectopic/Tubal ____ , Living Children ____, C-Sections _____,

Age of first pregnancy _____; Age at last pregnancy_____

Breastfeeding? ____ Currently, ____ In the past, _____ Never

If Currently, have you had any problems with breastfeeding? ___ YES ___ NO

List any problems with a pregnancy, birth or abortion: _____

_____

**Lifestyle/Challenges/Support:**

Any recent major life changes? ___ YES ___ NO If YES, what? _____

Any concerns regarding weight or eating? ___ YES ___ NO If YES, What? _____

Are you being abused sexually, physically or emotionally? ___ YES ___ NO If YES, how so?

_____

Are you being forced to do something against your will? ___ YES ___ NO If YES, what?

_____

Are you being bullied? ___ YES ___ NO. If YES, ___ At School ___ At Home ___ Both

Do you have a good support system? ____ YES ___ NO If YES, who? _____

Do you eat a healthy diet? ___ YES ___ NO

Do you exercise regularly? ___ YES ___ NO If YES, what do you do? _____

Do you work? ___ YES ___ NO If YES, ____ Full Time ___ Part Time

Are you a Student? ___ YES ___ NO If YES, ____ Full Time ___ Part Time

**Mental Health:**

Do you have **little** interest or pleasure in doing things? ___ YES ___ NO

Do you have a feeling of being down, depressed or hopeless? ___ YES ___ NO

Are you feeling suicidal? ___ YES ___ NO

Are you seeing a therapist or psychiatrist? ____ YES ___ NO

Do you have anxiety? ____ YES ___ NO

Please check each of the following conditions you may currently have or have had in the past:

| **Current** | **Past** | Conditions / Comments / Duration |
|---|---|---|
| _____ | _____ | Headaches _____ |
| _____ | _____ | Migraines _____ |
| _____ | _____ | Fatigue _____ |
| _____ | _____ | Sinus _____ |
| _____ | _____ | Sleep Disturbances _____ |
| _____ | _____ | Visual Disturbances _____ |
| _____ | _____ | Pain - where?_____ |

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| | | |
|---|---|---|
| _____ | _____ | Infections _____ |
| _____ | _____ | Fever _____ |
| **Current** | **Past** | Conditions / Comments / Duration |
| **Skin Conditions** | | |
| _____ | _____ | Rashes _____ |
| _____ | _____ | Athlete's Foot _____ |
| _____ | _____ | Warts _____ |
| _____ | _____ | Dry Skin _____ |
| _____ | _____ | Skin Lesion _____ |
| _____ | _____ | Moles (growth/change) _____ |
| _____ | _____ | Other _____ |
| **Muscles & Joints** | | |
| _____ | _____ | Arthritis – type? _____ |
| _____ | _____ | Broken Bones _____ |
| _____ | _____ | Auto-Immune – type?_____ |
| _____ | _____ | Sprains/Strains _____ |
| _____ | _____ | Weak/Sore Muscles _____ |
| _____ | _____ | Scoliosis _____ |
| _____ | _____ | Spasms/Cramps _____ |
| _____ | _____ | Back, Leg, Neck Pain _____ |
| _____ | _____ | Shoulder, Arm, Wrist Pain _____ |
| _____ | _____ | Stiff and/or Painful Joints _____ |
| _____ | _____ | Other _____ |
| **Nervous System** | | |
| _____ | _____ | Head Injury/Concussion _____ |
| _____ | _____ | Depression _____ |
| _____ | _____ | Sciatica /Shooting Pain _____ |
| _____ | _____ | Chronic Pain _____ |
| _____ | _____ | Numbness/Tingling _____ |
| _____ | _____ | Dizziness/Ear Ringing _____ |
| _____ | _____ | Loss of Memory/Confusion _____ |
| _____ | _____ | Tics/Spasms/Double Vision _____ |
| _____ | _____ | Fainting _____ |
| _____ | _____ | Other _____ |
| **Respiratory & Cardiovascular** | | |

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| | | |
|---|---|---|
| _____ | _____ | Heart Disease _____ |
| _____ | _____ | Poor Circulation _____ |
| _____ | _____ | Shortness of Breath _____ |
| **Current** | **Past** | Conditions / Comments / Duration |
| _____ | _____ | High/Low Blood Pressure _____ |
| _____ | _____ | Asthma _____ |
| _____ | _____ | Chest pain _____ |
| _____ | _____ | Lymphedema _____ |
| _____ | _____ | Palpitations _____ |
| _____ | _____ | Irregular Heart Beat _____ |
| _____ | _____ | Blood Clots _____ |
| _____ | _____ | Swollen Ankles _____ |
| _____ | _____ | Stroke _____ |
| _____ | _____ | Varicose Veins/Hemorrhoids _____ |
| _____ | _____ | Other _____ |

**Digestive/Elimination System**

| | | |
|---|---|---|
| _____ | _____ | Bowl Dysfunction _____ |
| _____ | _____ | Gas/Bloating _____ |
| _____ | _____ | Kidney Dysfunction _____ |
| _____ | _____ | Liver Problems _____ |
| _____ | _____ | Abdominal Pain _____ |
| _____ | _____ | Bladder Dysfunction _____ |
| _____ | _____ | Diarrhea _____ |
| _____ | _____ | Constipation _____ |
| _____ | _____ | Urination Difficulty _____ |
| _____ | _____ | Painful Urination _____ |
| _____ | _____ | Blood in Urine _____ |
| _____ | _____ | Other _____ |

**Endocrine System**

| | | |
|---|---|---|
| _____ | _____ | Thyroid Dysfunction _____ |
| _____ | _____ | Diabetes _____ |
| _____ | _____ | Alopecia (Hair Loss) _____ |
| _____ | _____ | Cold or Heat Intolerance _____ |
| _____ | _____ | Excessive hunger or thirst _____ |
| _____ | _____ | Other _____ |

**Reproductive System**

| | | |
|---|---|---|
| _____ | _____ | Pregnancy _____ |
| _____ | _____ | Fibrotic Cysts _____ |
| _____ | _____ | Painful Menses _____ |
| **Current** | **Past** | Conditions / Comments / Duration |
| _____ | _____ | Lack of Menses _____ |
| _____ | _____ | Unusual vaginal bleeding _____ |
| _____ | _____ | Unusual vaginal discharge _____ |
| _____ | _____ | Pelvic Pain _____ |
| _____ | _____ | Breast Discharge _____ |
| _____ | _____ | Brest Lump _____ |
| _____ | _____ | Swollen testicle(s) _____ |
| _____ | _____ | Testicular Lump _____ |
| _____ | _____ | Testicular Pain _____ |
| _____ | _____ | Erectile Dysfunction _____ |
| _____ | _____ | Other _____ |

**Cancer/Tumors**

| | | |
|---|---|---|
| _____ | _____ | Benign _____ |
| _____ | _____ | Malignant _____ |

**Communicable Diseases**

| | | |
|---|---|---|
| _____ | _____ | HIV _____ |
| _____ | _____ | Gonorrhea _____ |
| _____ | _____ | Herpes _____ |
| _____ | _____ | Chlamydia _____ |
| _____ | _____ | Syphilis _____ |
| _____ | _____ | Warts _____ |
| _____ | _____ | Hep B/C _____ |
| _____ | _____ | Other _____ |

**E) Family Medical History**

**Father:** Alive?: YES NO If alive, current age _____,

My Father's general health current or previous is/was: _____ Excellent, _____ Good, _____ Fair, _____ Poor

If deceased, age and cause of death _____

Please check if your father had any of the following conditions:

_____ Heart attacks, _____ Strokes, _____ High blood pressure, _____Elevated Cholesterol, _____ Obesity,

_____ Diabetes, _____ Asthma, _____Hay Fever, _____ Heart Disease, ____ Congenital Heart Disease

_____ Glaucoma, _____ Leukemia/Lymphoma, _____ Cancer – type? _____ , ____ Dementia,
_____ Other _____

**Mother:** Alive?: YES NO If alive, current age _____,

My Mother's general health current or previous is/was: _____ Excellent, _____ Good, _____ Fair, _____ Poor

If deceased, age and cause of death _____

Please check if your Mother had any of the following conditions:

_____ Heart attacks, _____ Strokes, _____ High blood pressure, _____Elevated Cholesterol, _____ Obesity,
_____ Diabetes, _____ Asthma, _____Hay Fever, _____ Heart Disease, ____ Congenital Heart Disease
_____ Glaucoma, _____ Leukemia/Lymphoma, _____ Cancer – type? _____ , ____ Dementia,
_____ Other _____

**Siblings:** Number of Brothers: _____ Number of Sisters: _____ Ages : _____

Health Problems?: _____

I have answered all the questions about my medical history and my present physical condition fully and truthfully. I have told the doctors or other designated health center personnel about any conditions I may have, which may affect my overall health care. It is my responsibility to inform my provider should this information change in the future. I understand that I am a participating member of my health care team. I understand that there may be choices in treatment options and that I am responsible for following the treatment plan that I have chosen as the best course of treatment. I understand that should I disagree with the treatment options and medical diagnosis that I am free to seek a second opinion. I understand that should I have a terminal illness there is no guarantee of a cure. I grant Touchstone Health Clinic permission to perform such tests, treatments and procedures as ordered by the medical staff for diagnostic and/or therapeutic purposes. As part of the testing and treatment I may receive disease-specific prevention, education, and risk-reduction services. I understand that Touchstone Health Clinic is required by law to report information on some communicable diseases to Washington State Department of Health.

By signing below, I confirm that I have reviewed and answered this entire document. Any spaces left blank are not applicable to me.

Patient Signature: _____ Date: _____

Reviewing Provider Signature**: _____ Date: _____

** By signing above I confirm that I have reviewed the entire document and obtained clarification form the patient as necessary. Any blank spaces in this history form should be lined through by the patient and initialed by the reviewing provider to identify that if is not applicable to the patient.

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# Consent for Purposes of Treatment, Payment & Health Care Operations

I consent to the use or disclosure of my protected health information by Touchstone Health Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment or my health care bills or to conduct health care operations of Touchstone Health Clinic.

I understand that diagnosis or treatment of me by providers at Touchstone Health Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Touchstone Health Clinic is not required to agree to the restrictions I request. However, if Touchstone Health Clinic agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that Touchstone Health Clinic has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

Your provider at Touchstone Health Clinic will keep a record of the health care services provided to you. You may ask to see a copy of that record. Your provider will not disclose your record to others unless you direct them to do so or unless the law authorizes or compels them to do so. You may also ask to correct your record. You may also get more information about this by contacting your provider at Touchstone Health Clinic.

Print Name: _____ Date: _____

Signature: _____

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## Patient Bill of Rights

- To receive quality medical, behavioral and mental health services regardless of your age, sex, religion, national origin, sexual preference, disability, health status or ability to pay.
- To seek a consultation with the physician(s) or provider of choice.
- To be treated with respect by Touchstone Health Clinic.
- To information contained in your medical record (except when exempt under State and Federal Law).
- To have a right to participate in decisions involving your health care.
- To use your own resources to purchase the care of your choice (based on medical necessity).
- To refuse medical treatment even if it is recommended by their physician(s) or provider.
- To personal privacy. Any discussion consultation, examination and/or treatment regarding your care will be done discreetly.
- To confidentiality of your medical record and other information related to your medical condition.
- To be informed about your medical or mental health condition, the risks and benefits of treatment and appropriate alternatives.
- To receive full disclosure of your insurance plan in plain language (to the best of our abilities).
- To be seen in a safe and clean environment.
- To file a complaint about your care without fear of penalty, to have your complaint reviewed, and when possible, resolved.

## Patient Responsibilities

- To **provide**, to the best of your knowledge, **complete information** about your symptoms, past illness and medical history, medications and other matters relating to your health.
- To schedule and **keep your appointments**, or to call to cancel your appointments in a timely fashion.
- To **arrive on time**, if you do not arrive on time, you acknowledge that your appointment time may be cut short, and/or your appointment may have to be rescheduled.
- To **notify the clinic of any demographic changes**, including but not limited to, changes in insurance coverage, address, and phone number.
- To **ask questions** when you do not understand explanations about your care or services.
- To **be responsible** for your actions, if you refuse treatment or do not follow your providers instructions.
- To follow the organization policies.
- To be **courteous** and **considerate** of Touchstone Health Clinic's staff, providers, interns and other clients; please be aware that **aggressive, abusive, or threating behavior towards staff, providers, interns and/or other clients by clients and/or their representative, will not be tolerated.**
- To understand your insurance plan and agreement with your insurance company regarding your financial responsibility for services provided.
- **Failure to follow patient responsibilities** may result in a formal discharge from services rendered at Touchstone Health Clinic.

Patient Signature: _____Print Patient Name: _____

Date: _____

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**Notice of HIPAA Privacy Practices:** Acknowledgement of Receipt of HIPAA Privacy Practices

- I understand I have a right to review Touchstone Health Clinic's Notice of Privacy Practices prior to signing this document.
- Touchstone Health Clinic's Notice of Privacy Practices has been provided to me.
- The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Touchstone Health Clinic.
- The Notice of Privacy Practices for the providers at Touchstone Health Clinic is also provided at the front desk of Touchstone Health Clinic.
- This Notice of Privacy Practices also describes my rights and the duties of the providers at Touchstone Health Clinic with respect to my protected health information.
- Touchstone Health Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
- I may obtain a revised notice of privacy practices by calling the office and requesting revised copy be sent in the mail or asking for one at the time of my next appointment.
- By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices and have had an opportunity to discuss any questions I may have.

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Date: _____

******For Provider Use Only ******

Client (or personal representative) is unable or unwilling to sign this documents for the following reasons:

_____

_____

Describe attempts to obtain Signature: _____

_____

Provider Name: _____ Provider Signature: _____Date: _____

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## Insurance Disclosure/Assignment of Benefits/Financial Responsibility

By signing this document client acknowledges their financial responsibility for medical and/or mental health bills that result from deductibles, co-insurance, co-pays, non-covered services, missed appointment fees and other outstanding fees. Client is also aware of the potential reasons for Non-Covered Services and that a certain portion of the patient's care may not be covered by or may not be authorized by the patient's insurance plan. The most important thing is that patient's receive care and support needed, regardless of having an outstanding balance. Should finances be of concern, Touchstone Health Clinic respectfully requests that patient's be put on a payment plan to help cover outstanding costs. Payment plans are based on a sliding scale with factors such as income and household size based on the Federal Poverty Level for the current year. If we are unable to collect payment or arrange a payment plan with a patient, a payment collection service may be used for payment collections purposes, Touchstone Health Clinic reserve the right to charge 1% on outstanding balances, per Washington State Allowable Laws.

**I authorize Touchstone Health Clinic to bill (name of the Ins. Company): _____ to pay by check or direct deposit made out directly to:**

**Touchstone Health Clinic, PLLC.**

This is a direct assignment of my benefits and rights under this policy. This payment will not exceed my indebtedness to the assignee and I have agreed to concurrently pay any balances of said services which may exceed this insurance payment.

Signature of Policy Holder: _____ Date: _____

Signature of claimant, if not policy holder: _____ Date: _____

There is a possibility that insurance may not cover your services. This may be because of the following listed reasons.

**Potential reasons for Non-Covered Services**

- The service is or may be deemed investigational and/or experimental under the carrier's internal guidelines.
- The service is considered or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
- The service and/or diagnosis may not be covered under the plan to which the patient is subscribed.
- The service and/or diagnosis may require pre-authorization which may not have been received or may have been denied, under the cost management guidelines of the policy.
- The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

**The carrier authorizes the provider to charge the patient for services so long as this disclosure is made and signed by the patient prior to their services being provided.**

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## Notice of Missed Appointment Policy

All appointments are scheduled time between you and your provider; therefore, when an appointment is missed, someone else could have had that scheduled time with the provider.

**Twenty-four** (24) hour advanced notice is required for an appointment cancellation.

If this notice is not given, Touchstone Health Clinic reserves the right to charge you a $35.00 missed appointment fee. It is important to understand that insurance companies do not pay for this fee.

**Please keep your appointments**.

Thank-you!

I have read and agreed to the information provided above.

Patient Name: _____ Date: _____

Patient Signature: _____