Family Medicine Liberty Lake
1431 N. Liberty Lake rd
Liberty Lake, WA 99019
Phone- 509-928-6700
Fax-509-928-0861
familymedll.com

PATIENT INFORMATION

Patient Name: _____ **SSN**_____

Alias/ Nickname:_____ **Maiden Name:**_____

Date of Birth _____ **Sex** ☐ M ☐ F **Marital Status** ☐ S ☐ M ☐ D ☐ W

Mailing Address: _____ **Apt/unit #**_____

City _____ **State**_____ **Zip** _____

Home Phone (_____)_____ **Cell Phone** (_____)_____

Work Phone (_____)_____ **Employer/School:**_____

Email Address_____

Are you interested in signing up for the patient portal? Yes / No

Language Preference:_____ **Race:** _____ **Ethnicity:**_____

Emergency Contact Information

Emergency Contact Name _____Relationship to Patient _____

Address: _____ Apt/unit #_____

City _____ State_____ Zip _____

Emergency Contact Phone (_____)_____

Guarantor/ Guardian Information

Guarantor/Guardian Name _____ SSN_____

Date of Birth _____Relationship to Patient _____

Address: _____ Apt/unit #_____

City _____ State_____ Zip _____

Home Phone (_____)_____Cell Phone (_____)_____

Work Phone (_____)_____Employer _____

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Patients insurance information (please provide your insurance card and photo ID to the receptionist)

Primary Insurance Company Name _____

Name of Policy Holder _____ Date of Birth _____

Relationship to patient _____ SSN _____

Insurance ID _____ Group Number _____

Secondary Insurance Company Name _____

Name of Policy Holder _____ Date of Birth _____

Relationship to patient _____ SSN _____

Insurance ID _____ Group Number _____

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Patient name_____ Date of Birth _____ Date_____

Check if you have had any of the following and give approximate dates

Illnesses: ***Dates***

- Anemia _____
- Arthritis _____
- Asthma _____
- Bladder infections _____
- Bleeding tendency _____
- Bronchitis _____
- Cancer: site/type _____
- Colitis _____
- Diabetes I or II _____
- Diverticulitis _____
- Emphysema _____
- Epilepsy/ Seizures _____
- Gout _____
- Hay fever _____
- Heart disease _____
- Hemorrhoids _____
- Hepatitis A/B/C _____
- Hiatal hernia _____
- Kidney disease _____
- Meningitis _____
- Pleurisy _____
- Pneumonia _____
- Rheumatic fever _____
- Stroke _____
- TB or Exposure _____
- Thyroid Disease _____
- Hypothyroid _____
- Hyperthyroid _____
- Ulcers _____
- Other_____ _____

_____

Surgeries

- Appendix _____
- Breast _____
- Gallbladder _____
- Heart _____
- Hemorrhoids _____
- Hernia _____
- Prostate _____
- Stomach _____
- Thyroid _____
- Tonsils or Adenoids _____
- Uterus and/or Ovaries _____
-
- Full hysterectomy _____
  - o Yes
  - o No
- Varicose veins _____
- Other _____

_____

Medication taken

_____None

Name *Dose* *Amount taken daily*

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies:

- None
- Penicillin's
- Sulfas
- Latex
- Codeine
- Other_____

_____
_____
_____

Family History

age if living health problems age at death cause of death

Father_____

Mother_____

Siblings-

1. _____
2. _____
3. _____
4. _____

Social History

Do you currently smoke? ☐ Yes ☐ No

Packs per day _____How many years have you smoked _____

How many years ago did you *Quit Smoking*_____

Have you ever smoked? ☐ Yes ☐ No ☐

Alcohol _____

Marijuana/ or other Drugs _____

Caffeinated Beverages _____

Marital Status: Married ☐ Widowed ☐ Divorced

Single ☐ Separated ☐ Sig. Other ☐

Do you have an Advanced Directive (Living will/ per of attorney)

☐ Yes ☐ No

If not, would you be interested in having one?

☐ Yes ☐ No

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HIPAA Privacy

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means. Such as sending correspondence to the individual office's instead of their home.

I wish to be contacted in the following manner (please check all that apply)

_____It is okay to leave a message with detailed information OR _____Leave call back number only

I give permission for all staff and doctors of Family Medicine Liberty Lake to discuss my patient care and billing account with the following person(s)

Name_____ Relationship_____

Name _____ Relationship _____

Financial Policies

I agree to pay for services rendered as the charge is incurred. I understand that healthcare and accident insurance policies are arrangements between insurance carrier and myself that I am personally responsible for payment of all **services, covered or non-covered**. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all **co-payments, co-insurances, deductibles and non-covered services**. I also agree to pay for **all copays and non-covered services** after seeing the doctor. I authorize the doctor and his/her staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse. Claims review, employer, healthcare provider of attorney in order to process any claim for reimbursement or changes incurred by me as a result of the profession services rendered and hereby released and hereby release him/her of any consequences thereof. I hereby authorize and direct payment of any and all medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for the professional services rendered.

If required by my health insurance policy it is my responsibility to obtain a referral from my primary care physician prior to treatment at Family Medicine Liberty Lake. I also understand that if I do not have prior authorization and it is denied, I am responsible for any charges not covered by my insurance company. Benefits are sometimes misquoted by the insurance company, and I understand that I am responsible for all services rendered, regardless of how I was quoted.

Cancellation Policy

We realize that emergencies come up, but if you need to cancel an appointment for any reason, we do require 24 hours' notice. We do have a waiting list of other patients who are in pain and are needing to be seen as soon as possible, By giving us adequate notice of tour cancellation, we are able to help others more quickly. If you **DO NOT** contact our office prior to your scheduled appointment you will be given 1 strike per missed appointment. At 3 strikes we will dismiss you from our office and will no longer be able to provide medical care.

Time of Service Discount

If you are paying cash we do give a 20% discount at the time of service. You must pay the full amount directly after you were seen in order to get the discount. If we have to bill any part of your visit out to you, we will be unable to give you the 20% discount.

_____ _____ _____

Patient's OR Guardian Printed Name ***Patient's*** OR Guardian Signature Date

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CONSENT TO TREATMENT AND ACKNOWLEDGEMENT OF FAMILY MEDICINE LIBERTY LAKE POLICIES AND PRACTICES

It is important as a patient of Family Medicine Liberty Lake you understand you rights and responsibilities, and that you understand our policies and practices. Please read the information below carefully.

1. **CONSENT TO TREATMENT:** I voluntarily consent to the medical care, medical and surgical treatment and procedures that may include diagnostic procedures, tests, anesthesia and radiology procedures and laboratory tests that are ordered by the physician.

2. **NO GUARANTEE:** I understand that medicine and surgery are not exact sciences and diagnosis and treatment may involve risks of injury or death. I understand and acknowledge that no guarantee or assurances as to results have been made.

3. **PATIENTS RIGHTS REGARDING MEDICAL CARE:** I understand I have the right to make decisions, by law, concerning my medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advanced Directives regards these rights.

4. **NOTICE OF PRIVACY PRACTICES:** I have been provided information about my rights, as pertain to the use and disclosure of my personal health information. I acknowledge the Family Medicine Liberty Lake will use my information for treatment, payment and healthcare operations. I have been given a copy of the Notice of Privacy Practices and have been given the opportunity to ask questions. I understand that if I have additional questions or concerns, I may contact the office.

5. **NO DISCRIMINATION:** I understand that Family Medicine Liberty Lake does not discriminate on the basis of age, sex, marital status, race, creed, color, national origin, or the presence of any sensory, mental, or physical handicap(s).

6. **NO SMOKING:** I understand that Family Medicine Liberty Lake has a NO smoking policy that includes all patient rooms and on Family Medicine Liberty Lake property.

7. **PAYMENT:** I understand that I am responsible for supplying accurate billing information to Family Medicine Liberty Lake. I understand that I am responsible for all charges incurred as part of my medical care.
8. **PATIENT PHOTOGRAPHS:** I understand that I may be asked to provide photo ID as a condition of my care. I also understand that a photograph of me may be incorporated into Family Medicine Liberty Lake electronic health record.

9. **VERBAL AND/OR PHYSICAL ABUSE:** I understand that all Family Medicine employees have the right to be treated with dignity and respect at **ALL TIMES**. They should be able to do their jobs **WITHOUT** being physically and/or verbally abused.

Patients Signature: _____ Date: _____

Legal Representative, if other than patient: _____ Relationship: _____

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*****THIS IS IF WE NEED TO REQUEST RECORDS FROM ANOTHER DOCTORS OFFICE*****

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENTS FULL NAME: _____
MAIDEN NAME/ALIAS: _____
PATIENTS DATE OF BIRTH: _____
PATIENTS SOCIAL SECURITY NUMBER: _____

THE HEALTHCARE INFOMATION THAT I AUTHORIZE TO BE RELEASED IS *(what is being sent):*

- **ALL HEALTHCARE INFORMATION** in medical record
- Health care information in the medical record related to the following treatment or condition: _____
  _____
- Health care information in the medical record for the date(s): _____
- Other (e.g. x-rays, bills), specify date(s): _____

INCLUDE* THE FOLLOWING INFORMATION FROM THE RECORDS RELEASED (*PLEASE INITIAL):

MENTAL NOTES____ DRUG AND/ OR ALCOHOL USE ____ SEXUALLY TRANSMITTED DISEASES: ____
HIV (AIDS virus) ____ Other: _____

THIS RECORD IS REQUESTED FOR THE FOLLOWING REASON:

- TRANSFER OF CARE
- PERSONAL INTEREST
- GOING TO SPECIALIST
- LEGAL PURPOSES
- INSURANCE PURPOSES
- OTHER (specify)_____

I request and authorize: (records **coming from**):
Clinic/Provider: _____
Address: _____
City_____ State_____ Zip Code_____
Phone: _____ Fax: _____

I request and authorize: (records **going to**):
Clinic/Provider: FAMILY MEDICINE LIBERTY LAKE
Address: 1431 N. LIBERTY LAKE RD STE B
City: LIBERTY LAKE State WA Zip Code 99019
Phone: 509-928-6700 Fax: 509-928-0861

I understand that there may be a charge for this service, and I agree to pay said charge on demand.

I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. If Family Medicine Liberty Lake is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will *not* affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit edibility. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

SIGNATURE: _____ DATE_____
Patient, Parent, or Legally Authorized Individual
Relationship to Patient:_____

Social Security Number: _____ Phone Number: _____

Expiration: This authorization expires on this date or event: _____. **I understand this authorization will expire 90 days for the date signed if no specific expiration date is indicated.** The authorization may be revoked by notifying Family Medicine Liberty Lake in writing at any time except action has been taken prior to revocation.