ADVANCED FAMILY MEDICINE, PLLC

PATIENT REGISTRATION FORM

PATIENT INFORMATION ***(please write information about the patient here.)***

PATIENT'S NAME (Last, First Middle Initial)	SEX	AGE	SOCIAL SECURITY NUMBER
	☐ Male ☐ Female		
PATIENT'S ADDRESS		**MARITAL STATUS**	**DATE OF BIRTH**
		☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed	_____/_____/_____ MO DAY YR
CITY	**STATE ZIP**	**ETHNICITY**	
		☐ Hispanic or Latino ☐ Patient declined to specify ☐ Not Hispanic or Latino	
HOME PHONE	**MOBILE PHONE**	**PREFERRED LANGUAGE**	
( )	( )		
EMAIL ADDRESS		**RACE (S)**	
		☐ American Indian / Alaska Native ☐ Black / African American ☐ White / Caucasian ☐ Asian ☐ Native Hawaiian / Other Pacific Islander ☐ Patient Declined to specify	

POLICYHOLDER INFORMATION
(Complete below if the PATIENT is NOT the POLICYHOLDER)

IN CASE OF AN EMERGENCY WHO SHOULD WE CONTACT?
(Please list someone not living at a residence)

PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial)	DATE OF BIRTH	NAME	
	_____/_____/_____ MO DAY YR		
SOCIAL SECURITY NUMBER	**RELATIONSHIP TO PATIENT**	**ADDRESS**	
	☐ SPOUSE ☐ PARENT _____ OTHER	**CITY**	**STATE ZIP**
EMPLOYER'S NAME	**PHONE NUMBER**	**DAY PHONE**	**EVENING PHONE**
	( )	( )	( )

Please remember the insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurances may pay fixed allowances for certain procedures, and others may pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-insurance, or any other balances not paid for by the insurance.

IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

SIGNATURE X _____ **DATE** _____

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement of the claim.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to Advanced Family Medicine Pllc.

This assignment will remain in effect until is revoked by me in writing. A photocopy of this assignment is to be considered as valid and original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I agree to the assignments and financial responsibilities shown on the top of this form.

SIGNATURE X _____ **DATE** _____

ADVANCED FAMILY MEDICINE. PLLC

FINANCIAL POLICY

We are committed to providing the best treatment for our patients and our practice charges usual and customary rates for our area.
We accept payment for your treatment from your insurance company. As a service to you, we will bill your insurance company, but it is your responsibility to provide us with correct insurance information at the time of every visit.

Your insurance policy is a contract between YOU and YOUR INSURANCE COMPANY. You need to be aware about details of your policy: deductibles, co pays, coinsurance, payments for routine services, the need for preauthorization for different procedures, the need for referrals to specialists, ext. All co pays are due at the time of service.

Depending on your policy you will receive the bills from us within 10-30 days after your insurance company determines patient responsibility. If bill is not paid within 60 days account will be send to collection agency.
The processing fee of 30% of the total bill will apply to all bills that were not paid within 60 days.

Payment for services provided for patients without insurance coverage is due at the time of service. Processing discount available at the time of service only.

We reserve the right to bill patient $60.00 for missed appointments or appointments cancelled less then 24 hours in advance.

We accept cash, personal checks or VISA/MASTER card.

All patients must complete patient registration form before seeing a health care provider.

I have read, and agree to this Financial Policy

Patients Name _____

Signature _____ Date _____

ADVANCED FAMILY MEDICINE, PLLC
CONSENT TO LEAVE MESSAGES

I, _____ give Advanced Family Medicine PLLC permission to:
Printed Name

	Please Circle	
Leave a message regarding test results on my answering machine.	**YES**	**NO**
Leave a message with someone who may answer phone at my residence.	**YES**	**NO**

_____
Signature

_____ _____ _____
Home Phone Mobile Phone Work Phone

_____ _____ _____
Home Phone Mobile Phone Work Phone

I authorize AFM PLLC to disclose information and or review my care with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Important please provide us with Name & Number of Preferred Pharmacy

_____ _____
Pharmacy Name Pharmacy Number

_____
Signature (**This form will be retained in your medical record**)

ADVANCED FAMILY MEDICINE, PLLC
HIPAA NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.**
2. **IT IS OUR LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

Advanced Family Medicine, PLLC is required to provide you with this Notice about privacy procedures. We must explain when, why, and how we would use and/or disclose your PHI.

By law, we are required to ensure that your PHI is kept private and to follow the privacy practices described in this Notice.

PHI is information created or noted by Advanced Family Medicine, PLLC that can be used to identify you. It may contain data about your past, present, or future health or condition, the provision of health care services to you, or the payment of such health care.

Use of PHI means that we share, apply, utilize, examine, or analyze information within the practice.

Disclosure of PHI is when we release, transfer, give, or otherwise reveal it to a third party outside the practice. With some exceptions, we may use or disclose the PHI necessary to accomplish the purpose for which the use or disclosure was made.

Advanced Family Medicine, PLLC reserves the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI already on file. Before any important changes are made to the policies, the Notice will be changed, and you will be given a copy of the new alterations.

3. **USE AND DISCLOSURE OF YOUR PHI**

Some uses, or disclosures of PHI will require your prior written authorization; others will not. Information will be disclosed only to the extent that knowledge of the record or communications is essential to the purpose for which disclosure is made and only after you have been informed that the disclosure is being made. A person to whom disclosure is made may use it only for the purpose for which the disclosure was made and, according to Washington law, may or may not re-disclose any information except as provided by law.

A) Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your consent for the following reasons:

1) For treatment: Your PHI may be disclosed, with your written consent, for the purposes of collaborating with other professionals. To any department, agency, institution or facility that has custody of you pursuant to State statute or any court order of commitment.

2) For healthcare operations. We may disclose your PHI to facilitate the efficient and correct operation of our practice. Examples: Quality Control- the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. We may also provide your PHI to the company attorney, to make sure that there is compliance with applicable laws.

3) To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment services provided you. Example: Your PHI may be sent to your insurance company or health plan in order to get payment for the health care services provided to you. We could also provide your PHI to the billing service (Premier Medical Billing Services) that processes claims for the office.

4) Other disclosures. Examples: Your consent is not required if you need emergency treatment provided that attempt to get your consent after treatment is rendered. If I try to get your consent but you are unable to communicate (i.e. if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B) Other Uses and Disclosures That Do Not Require Consent. These Include:

1) When disclosure is compelled by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.

2) If disclosure is compelled by a party proceeding before court or an administrative agency pursuant to its lawful authority. (This would ordinarily involve a court-approved subpoena.)

3) If disclosure is required by a search warrant lawfully issues to a governmental law enforcement agency.

4) If disclosure is compelled by you or your guardian or legally appointed representative pursuant to Illinois law or corresponding federal statutes or regulations, such as the Privacy Rule that requires this Notice.

5) To avoid harm. We may disclose PHI when, in our discretion, we determine that disclosure is necessary to initiate or continue civil commitment proceedings for involuntary hospitalization or to otherwise protect you or another person against a clear, imminent risk or serious physical or mental injury or disease or death being inflicted upon you or by you on yourself or another.

6) If disclosure is compelled or permitted by the act that you tell us of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

7) If disclosure is mandated by Washington law, such as the Child Abuse Reporting Law, the Sex Offender Registration Act, the Rights of Crime Victims and Witnesses Act, or Elder Abuse & Neglect Act.

8) For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, we may need to give the county coroner information about you.

9) For specific government functions. Examples: We may disclose PHI of military personnel and veterans under certain circumstances or in the interests of national security, as required or permitted by law, such as protecting the President of the United States.

10) For appointment reminders and health related information, benefits or services that may be of interest to you.

11) For oversight activities authorized by law. Example: When compelled by U.S. Secretary of Health & Human Services to investigate or assess compliance with HIPAA regulations.

12) If disclosure is otherwise specifically required by law.

C) Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in Sections IIIA and IIIB above, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke the authorization, in writing, to stop any future uses and disclosures of your PHI by Advanced Family Medicine, PLLC.

4. YOUR RIGHTS REGARDING YOUR PHI

A) The Right to See and Get Copies of Your PHI. If you are 12 years old or older, you have the right to see and get a copy of your PHI that is in my possession, not including private psychotherapy notes. If we do not have your PHI, but know who does, we will advise you how you can get it. You will receive a response in 30 days of receiving your written request. The charge for copies of your PHI will not exceed more than $1.17 per page first 30 pages and $0.88 per page all additional pages.

B) The Right to Request Limits on Uses & Disclosures of Your PHI. You have the right to ask that use and disclosure of your PHI be limited. Any such request will be carefully considered, but we are not legally bound to agree. If we do agree to your request, you will be so notified in writing, and we will abide by the limitations except in emergency situations. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make.

C) The Right to Choose How We Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We must agree to your request providing we can give you the PHI in that format you request without undue inconvenience.

D) The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, disclosures sent directly to you or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. Disclosure records will be held for six years. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list given to you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. The list will be provided to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

E) The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, you may request correction of the existing information or addition of the missing information. Your request and the reason for your request must be made in writing. If we find that PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone else, we must state the reasons for denial, and explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If we approve of your request, I will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made and advise all others who need to know about the change(s) to your PHI.

5. EASTSIDE HEALTH NETWORK PARTICIPATION

Advanced Family Medicine, PLLC participates in an organized health care arrangement ("OHCA") with other health care providers affiliated with the clinically integrated network operated by Eastside Health Network, LLC. The OHCA participants engage in certain joint quality assessment and improvement activities. As permitted by HIPAA, Advanced Family Medicine, PLLC may share the health information of its patients with the other OHCA participants for any health care operations activities of the OHCA. A list of all OHCA participants is available at: www.eastsidehealthnetwork.com.

6. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If, in your opinion, we may have violated your privacy right, or if you object to a decision made about access to your PHI, you are entitled to file a complaint with the person listed in **Section 6** below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

7. PERSON(S) TO CONTACT FOR INFORMATION ABOUT THIS NOTICE AND/OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this notice or any complaints about privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the practice at: Management Team at Advanced Family Medicine, PLLC., at 2007 152nd Ave NE, Redmond, WA 98052, telephone (425) 453-6838.

8. EFFECTIVE DATE OF THIS NOTICE

The effective date of this notice is September 27, 2019.

ADVANCED FAMILY MEDICINE, PLLC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Advanced Family Medicine, PLLC has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.
We may change the Notice of Privacy Practices at any time, and you may contact **Office Manager** at **425-453-6838** to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Advanced Family Medicine, PLLC.

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record!

For Office Use ONLY

Office staff complete below:

I have attempted to obtain this patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member's initials: _____

Reason(s):

_____

_____

ADVANCED FAMILY MEDICINE, PLLC

ADULT HEALTH HISTORY

Patient Name _____ Gender: ❑ Male ❑ Female Today's Date _____

Age ____ Birth date _____ Previous Physician: _____ Date of Last Physical: _____

What is your reason for visit? _____ How did you hear about us? _____

~* SYMPTOMS *~

Check (☑) symptoms you currently have or had in the last year.

GENERAL

- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Headache
- ❑ High blood sugar
- ❑ Insomnia/sleep prob.
- ❑ Irritable
- ❑ Loss of weight
- ❑ Low blood sugar
- ❑ Nervousness
- ❑ Numbness
- ❑ Weakness

GENITO-URINARY

- ❑ Blood in urine
- ❑ Difficulty urinating
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination
- ❑ Urine infections

MASCLE/JOINT/BONE

Pain, weakness, numbness in:

- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

GASTROINTESTINAL

- ❑ Bloating
- ❑ Bloody stool
- ❑ Change in bowel habits
- ❑ Constipation
- ❑ Decreased appetite
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gall bladder trouble
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion/heartburn
- ❑ Jaundice
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR

- ❑ Chest pain/angina
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

RESPIRATORY

- ❑ Coughing up blood
- ❑ Persistent cough
- ❑ Shortness of breath

EYE,EAR,NOSE & TROAT

- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Ear pain
- ❑ Ear discharge
- ❑ Eye pain
- ❑ Frequent ear infections
- ❑ Frequent sore throat
- ❑ Hay fever/allergies
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Stuffy nose
- ❑ Visual flashes or halo

SKIN

- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Sores that won't heal

MEN only

- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN only

- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Heavy periods
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period: _____
Period every _____ days
Are you pregnant? _____
Birth control method: _____
Number of children: _____
Number of miscarriages: _____
Date of last Pap Smear: _____
❑ Normal ❑ Abnormal
Date of last mammogram:_____
❑ Normal ❑ Abnormal

~* CONDITIONS *~

Check (☑) conditions you currently have had in the past.

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Anxiety
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken pox
- ❑ Colitis
- ❑ Depression
- ❑ Diabetes
- ❑ Emphysema /COPD
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Heart attack
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Infertility
- ❑ Kawasaki's disease
- ❑ Kidney disease
- ❑ Kidney stone
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine headache
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Murmur
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Panic Attacks
- ❑ Phlebitis
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ PTSD
- ❑ Rheumatic fever
- ❑ Seizure
- ❑ Sexually transmitted disease "STD"
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other

ADVANCED FAMILY MEDICINE, PLLC

ADULT HEALTH HISTORY

~* MEDICATIONS *~ Current prescription and over-the-counter medications

_____

_____

_____

Pharmacy Name: _____ Phone: _____

~* ALLERGIES *~

_____

_____

_____

_____

~* PAST HISTORY *~ Give names and dates

Previous Surgery _____

_____

_____

~* FAMILY HISTORY *~

	Age if living	Age at death	Medical conditions or cause of death
Father			
Mother			
Brothers			
Number__			
Sisters			
Number__			
Children			
Number__			
Number living in household:			

Check if any relatives have had: Relationship to you:

- ❑ Arthritis/Gout
- ❑ Asthma/Hay Fever
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Diabetes
- ❑ Heart Disease/Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Kidney Disease
- ❑ Mental Illness/Suicide
- ❑ Thyroid Trouble
- ❑ Tuberculosis
- ❑ Stroke
- ❑ Other

~* PERSONAL *~

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Sexual Preference: ❑ Male ❑ Female ❑ Both

Any history of sexual abuse? ❑ Yes ❑ No

Physical abuse? ❑ Yes ❑ No

Work Occupation: _____ Company: _____

Does you work expose you to:

❑ Stress ❑ Noise
❑ Heavy Lifting ❑ Hazardous Materials
❑ Other

Have you ever had a blood transfusions? ❑ Yes ❑ No

If so, please give date: _____

Smoking Packs per day: _____ Number years: _____ Year quit: _____

Type: ❑ Cigarette ❑ Pipe ❑ Cigar ❑ Chew

Do you have an interest in quitting? ❑ Yes ❑ No

Substance USE

Coffee - cups per day: _____

Aspirin - pills per day: _____

Street drugs used: _____

Have you ever used injection drugs? ❑ Yes ❑ No

Alcohol Usage: ❑ Never ❑ Moderate ❑ Rare ❑ Heavy

Alcohol Problems? ❑ Yes ❑ No

Exercise Amount: ❑ Sedentary ❑ Mild ❑ Moderate ❑ Heavy

Describe Activities: _____

Weight gain in last year? ❑ Yes ❑ No

Weight loss in last year? ❑ Yes ❑ No

Amount: _____

Autism Spectrum ❑ Yes ❑ No

Mental Health Problems ❑ Yes ❑ No

Suicide ❑ Yes ❑ No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

_____ _____

Signature of patient, parent or guardian Date

_____ _____

Printed name of patient, parent or guardian Relationship to patient

_____ _____

Reviewed by (Physician) Date