



Patient Information:

Provider: AK/SS

First Name _____ MI _____ Last Name _____
Maiden/Surname _____ Preferred Name _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone: _____ Preferred (circle one): Home/Cell
Date of Birth _____ Male/Female/Other _____ SSN _____
Place of Birth: _____ Race/Nationality: _____ Ethnicity: _____
Primary Language _____ E-Mail Address: _____
Married/Single/ Divorced/Widowed/Domestic Partner Social: Alone/ Family/ Assisted Living/Other: _____
Religion: _____ Occupation: _____
Spouse/Partner's Name: _____ Phone Number: _____
Emergency Contact Name: _____ Relationship: _____ Phone Number: _____
Previous Doctor _____ Phone Number: _____

Insurance Information Primary:

Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Relationship to Patient: _____

Insurance Information Secondary:

Policy Holder Name: _____ Policy Holder DOB: _____
Policy Holder Relationship to Patient: _____

I certify the above information given by me is correct and true.

Patient Name (PRINT) _____ **Date** _____

Patient or Legal Representative Signature _____ **Relationship** _____

Phone Messages: It is our policy to leave brief messages regarding lab results, imaging results and appointment dates and times. We do not leave messages for abnormal results.

If you do not wish to receive voicemail messages, please initial here: _____



Medical Information:

Patient Name: _____ **Date of birth:** _____

Alcoholic Beverages: Now/ Past/ Never

Tobacco Use: Now/ Past/ Never

Recreational Drugs: Now/ Past/ Never

Secondhand Smoke: Now/ Past/ Never

Immunization Dates:

Tetanus (TD, DPT): _____ Hepatitis A: _____ Hepatitis B: _____ MMR: _____

Pneumonia: _____ Shingles: _____ Tuberculosis Skin (TB): _____

Surgeries: Have you had the following surgeries (R=Right, L=Left, B=Both)?

Surgery: _____ **Date:** _____

Appendectomy: _____

Back Surgery: _____

Neck: _____

Low Back: _____

Breast Biopsy: **R / L / B** _____

Breast Implant: **R / L / B** _____

Mastectomy: **R / L / B** _____

Carotid Artery Surgery: _____

Surgery (cont.): _____ **Date:** _____

Cataracts: **R / L / B** _____

LASIK Eye Surgery: **R / L / B** _____

Gallbladder-Type: Laparoscopic or open

Surgeries: _____

Surgery: _____ **Date:** _____

Hernia: Location _____

Hysterectomy: _____

Abdominal _____ Vaginal _____

Ovaries left in **Y/ N** Ovaries out: **R / L / B**

Tubal Ligation _____

Joint/Bone Surgery: _____

Location _____ Side: **R / L / B**

Prostate Surgery: _____

Surgery: _____ **Date:** _____

Abdominal _____ Urethral _____

Tonsillectomy: _____

Vasectomy: _____ Other _____

Procedure Dates:

Colonoscopy: _____ Mammogram: _____ DRE: _____
(diabetic retinal exam)

Family Medical History: **** Has anyone in your family had? For Aunts/Uncle/Grandparents, Please indicate if they are Mother or Father's side, and age when they got the disease. ****

Disease:	Family Member:	Disease:	Family Member:
Cancer:		Coronary Artery Disease/Heart Disease:	
Breast	_____		_____
Colon	_____	Kidney Disease:	_____
Ovary	_____	Depression:	_____

Prostate	_____	Anxiety:	_____
Other	_____	Alcoholism:	_____
Colon Polyps:	_____	Thyroid Disease:	_____
Diabetes:	_____	Type:	_____
High Blood Pressure:	_____	Alzheimer's Disease:	_____
High Cholesterol:	_____	Migraines:	_____
Stroke:	_____	Other: _____	_____

Past Medical History: Please circle if you **Have Had** or **Have** any of the following disorders/diagnoses (indicate on the line P=Past or C=Current)

_____ ADD/ADHD	_____ Headaches
_____ Alcoholism	_____ High Blood Pressure (Hypertension)
_____ Allergies: Pollen/ Cats/ Dogs	_____ High Cholesterol/Lipids (Hyperlipidemia)
_____ Dust Mites/ Others: _____	_____ Transient Ischemic Attack
_____ Allergic Rhinitis	_____ Incontinence
_____ Anemia	_____ Irritable bowel syndrome :
_____ Anxiety	_____ Symptom: Diarrhea/Constipation/Pain
_____ Arthritis: Degenerative/Osteoarthritis:	_____ Insomnia
_____ What Joint: _____	_____ Kidney Stones
_____ Asthma	_____ Kidney Disease
_____ Atrial Fibrillation	_____ Liver Disease
_____ Bee Sting Allergy	_____ Low Back Pain
_____ Bipolar Disorder	_____ Migraine
_____ Cancer: Type: _____	_____ Neck
_____ Colitis: Type: _____	_____ Peripheral Artery Disease
_____ Coronary Artery Disease	_____ Prostate Enlargement
_____ Congestive Heart Failure	_____ Psoriasis
_____ Colon Polyps	_____ Pulmonary Embolism
_____ Constipation	_____ Restless Leg Syndrome
_____ COPD/ Emphysema	_____ Rosacea
_____ Dementia	_____ Seizure Disorder
_____ Depression	_____ Sleep Apnea
_____ Diabetes: Type: _____	_____ Stroke/TIA
_____ Erectile Dysfunction	_____ Thyroid Disorder
_____ Fibromyalgia	_____ Overactive/Underactive
_____ GERD/Heartburn	_____ Tremors
_____ Gout	_____ Ulcer: Where: _____
Other Diagnoses: _____	_____ Vein Clot

Children (List Sex/Birth Year): _____

Medications: Please list all prescription and nonprescription medications

Medications:	Dosage/Instruction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies:	Reaction:
_____	_____
_____	_____
_____	_____

Pharmacy Name: _____	Address: _____
Phone: _____	Fax: _____

I certify the above information given by me is correct and true.

Patient Name (PRINT) _____	Date _____
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Patient or Legal Representative Signature _____	Relationship _____
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Financial Policy

Thank you for choosing Hudson's Bay Medical Group as your healthcare provider. We are committed to providing each of our patients with quality healthcare in a way that is financially responsible for both our patients and our practice. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance billing:

- Be responsible for understanding details of your insurance coverage - including preventative care benefits, requirements for pre-authorization for procedures, annual deductibles, and copays/coinsurance.
- Provide us with a current copy of your card and notify us of any changes in insurance coverage. If we do not have current insurance billing information, the visit will be processed as "no insurance" (see below).
- Pay your copay at the time of service. Be responsible for any charges not paid by your insurance company within 45 days of our billing statement.

No insurance or for visits/services not covered by your carrier, we expect you to:

- Pay a payment of \$125 for new patients or physicals, \$75 for established patients or else pay in full at the time of service (unless prior arrangements have been made to accommodate a payment plan). When you pay in full at the time of service, we can offer you a "prompt pay" discount of 25%. Please refer to the 'Self Pay Agreement Form' for payment options.

Labor & Industries, Worker's Compensation, Motor Vehicle Accidents or Accident Liability Claims:

- Our office policy for motor vehicle accidents (MVAs) is to bill your personal injury protection (PIP) insurance. Please bring copies of your insurance card, the date of the accident and all pertinent information needed for billing. Please refer to the 'Motor Vehicle Accident Personal Injury Protection Insurance form'. We also need a copy of your regular medical insurance card in case the MVA is not covered.
- For Worker's Compensation visits, you need to bring the information for billing along with pertinent information regarding the injury. If you have already completed the paperwork, a copy will be needed at the time of your appointment. If you have not completed the paperwork yet, please allow an extra 20 minutes so we can get that taken care of.

Delinquent Accounts:

You will receive a monthly statement showing itemized charges and the total due on your account.

- In the event that a patient stops making payment on his/her outstanding balance for longer than 45 days, he/she will be considered as having a delinquent account.
- Patients with outstanding balances may have their accounts forwarded to a collection agency after 90 days of non-payment.
- In the event that a patient needs emergent or routine care and has a delinquent balance, they need to make payment arrangements with the business office.

Returned Checks:

A \$35 fee will be assessed to your account for each returned check. This fee and the original check amount must be paid in full by cash, credit card or a money order within 10 days.

NO SHOW POLICY: We have a no show fee of \$50. Insurance will not cover this charge; this will be patient responsibility. A no show appointment is an appointment that we did not receive 24hr notice for cancellation.

Billing Office Hours:

For your convenience, our Business Office is staffed Monday through Friday from 8:00 am to 4:00 pm. The phone number is (360) 992-1158. Our knowledgeable staff will be happy to address any questions or concerns you may have regarding our financial policy or your account.

Patient Name (PRINT): _____ **Date:** _____

Patient or Legal Representative Signature: _____ **Relationship:** _____



HIPAA

We keep a record of healthcare 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 records 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 the Privacy Officer. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access information.

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

Patient Name (Print): _____ **Relationship:** _____

Patient or Legal Representative Signature: _____ **Date:** _____

E-PRESCRIBING PBM (PRESCRIPTION BENEFIT MANAGER) CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that must be included in an ePrescribe program. These include:

-  **Formulary and benefit transactions**-Gives the prescriber information about which drugs are covered by the drug benefit plan.
-  **Medication history transactions**-Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you agree that Hudson's Bay Medical Group can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Please select from the options below and sign. Our office also requires 48-72-hour notice for prescription refills.

- ☐ **No:** You will receive a hand-written prescription which could slow down the process
- ☐ **Yes:** Electronic prescriptions

Patient Name (Print): _____ **Relationship:** _____

Patient or Legal Representative Signature: _____ **Date:** _____



PHI FOR FAMILY MEMBERS AND CAREGIVERS

Patients Name:

Date of Birth:

I, _____ give my permission to have my personal health information (PHI) released to the following family members or caregivers.

Name Relationship Phone number

Name Relationship Phone number

Name Relationship Phone number

I understand that by signing this agreement, I am giving my permission for the above listed people to discuss my personal health information (PHI), I also understand that this is valid until revoked in writing.

Patient signature

Date

