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: _____

Welcome to Hudson's Bay Medical Group. We are pleased that you have chosen us as your primary care provider.

As part of our practice policy, Hudson's Bay Medical Group does **not** provide or manage long-term pain treatment with controlled substance medications. Our providers will **not provide temporary ("bridge") prescriptions, courtesy refills, emergency refills, or assume management of controlled substance pain medications under any circumstances.**

Examples include, but are not limited to:

- Morphine
- Codeine
- Methadone
- Oxycodone
- Percocet
- Hydrocodone
- Vicodin
- Norco
- Dilaudid (hydromorphone)
- Buprenorphine (when prescribed for chronic pain)
- Tramadol

By signing below, I acknowledge that I have read, understand, and agree to Hudson's Bay Medical Group's Long-Term Pain Management Policy. I understand that Hudson's Bay Medical Group **will not prescribe, refill, manage, or provide referrals** for controlled substance medications used for the treatment of chronic pain. I understand that it is my responsibility to arrange ongoing pain management care with an appropriate provider if needed.

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

Patient Signature: _____

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:**	**Surgery:**	**Date:**
Appendectomy:	_____	Hernia: Location	_____
Back Surgery:	_____	Hysterectomy:	_____
Neck:	_____	Abdominal _____ Vaginal _____	
Low Back:	_____	Ovaries left in **Y/ N** Ovaries out: **R / L / B**	
Breast Biopsy: **R / L / B**	_____	Tubal Ligation	_____
Breast Implant: **R / L / B**	_____	Joint/Bone Surgery:	_____
Mastectomy: **R / L / B**	_____	Location _____ Side: **R / L / B**	
Carotid Artery Surgery:	_____	Prostate Surgery:	_____
Surgery (cont.):	**Date:**	**Surgery:**	**Date:**
Cataracts: **R / L / B**	_____	Abdominal _____ Urethral _____	
LASIK Eye Surgery: **R /L /B**	_____	Tonsillectomy:	_____
Gallbladder-Type: Laparoscopic or open		Vasectomy:	_____ Other
Surgeries: _____			

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
_____ Alcoholism
_____ Allergies: Pollen/ Cats/ Dogs
Dust Mites/ Others: _____
_____ Allergic Rhinitis
_____ Anemia
_____ Anxiety
_____ Arthritis: Degenerative/Osteoarthritis:
What Joint: _____
_____ Asthma
_____ Atrial Fibrillation
_____ Bee Sting Allergy
_____ Bipolar Disorder
_____ Cancer: Type: _____
_____ Colitis: Type: _____
_____ Coronary Artery Disease
_____ Congestive Heart Failure
_____ Colon Polyps
_____ Constipation
_____ COPD/ Emphysema
_____ Dementia
_____ Depression
_____ Diabetes: Type: _____
_____ Erectile Dysfunction
_____ Fibromyalgia
_____ GERD/Heartburn
_____ Gout
Other Diagnoses: _____

_____ Headaches
_____ High Blood Pressure (Hypertension)
_____ High Cholesterol/Lipids (Hyperlipidemia)
_____ Transient Ischemic Attack
_____ Incontinence
_____ Irritable bowel syndrome :
Symptom: Diarrhea/Constipation/Pain
_____ Insomnia
_____ Kidney Stones
_____ Kidney Disease
_____ Liver Disease
_____ Low Back Pain
_____ Migraine
_____ Neck
_____ Peripheral Artery Disease
_____ Prostate Enlargement
_____ Psoriasis
_____ Pulmonary Embolism
_____ Restless Leg Syndrome
_____ Rosacea
_____ Seizure Disorder
_____ Sleep Apnea
_____ Stroke/TIA
_____ Thyroid Disorder
Overactive/Underactive
_____ Tremors
_____ Ulcer: Where: _____
_____ 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 _____

Patient or Legal Representative Signature _____ Relationship _____

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:** _____

Hudson's Bay Medical Group Inc. P.S.

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

100

Fax:

Hudson's Bay Medical Group

E 33rd St, Ste. 206A
Vancouver, WA 98663
Phone (360) 695-1334,
(360) 707-7453

Patient Name: _____

Patient Date of Birth: _____

Information to be released from: _____
Name of Designated Facility or Provider

(_____)_____ _____
Fax **Address / Phone**

Information to be released to: Hudson's Bay Medical Group
Fax: (360) 707-7453

Information to be Released: ☒ Past 2 Years of Health Records

OR, if looking for specific information:

☐ Immunization Records ☐ Lab/Pathology Reports ☐ Procedure Reports ☐ History and Physicals
☐ Medication List ☐ Imaging Reports (No CD) ☐ Progress Notes ☐ Discharge Summaries
☐ Other: _____

Purpose of Disclosure: (check one)

☐ Attorney/Insurance ☐ Transfer Care/New PCP ☐ Specialist/Continuity of Care ☐ Personal

Method of Disclosure: (check one)

☐ Fax (default method) *** ☐ Mail ☐ Email

***** Incoming Records:** If page count is greater than 75 pages, please send Secure Email to lissette@hudsonsbaymed.com

By signing this authorization, I understand that:

- My records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted infections, drug and/or alcohol abuse, mental illness, or genetic testing. **I give my specific authorization for these records to be release unless initialed below: *If you wish to EXCLUDE the following information from the records released, please initial the lines below.**
  _____Drug/Alcohol Abuse diagnosis/treatment _____Sexually Transmitted Infections
  _____HIV/AIDS diagnosis/treatment/testing _____Mental Illness or Psychiatric diagnosis/treatment
  _____Genetic Testing
- I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment).
- I may revoke this authorization in writing. If this authorization is revoked, HBMG cannot undo disclosures already released under this authorization. Unless revoked, this authorization will expire (90) ninety days from the date signed.
  Any disclosure of information has the potential for re-disclosure and may not be protected by federal confidentiality laws.
- I may ask for a copy of this authorization.
- There may be a fee associated with my request. **RCW 70.02.030, 45 CFR 164.524**

_____ _____
Patient or Legally Authorized Representative* Signature Date

_____ _____
Relationship to Patient if signed on Behalf of Patient Printed Name if Signed on Behalf of Patient

100

Fax:

Hudson's Bay Medical Group Inc. P.S.

E 33rd St, Ste. 206A
Vancouver, WA 98663
Phone (360) 695-1334,
(360) 707-7453

Patient Name: _____

Patient Date of Birth: _____

[*Please provide documents to prove authority to sign on behalf of the patient.]