3080 148th Ave SE, Suite 115
Bellevue, WA 98007

PH: 425.378.8190

PATIENT INFORMATION					
Last Name			**First Name**		**M/initial**
Address					
Home Phone:			**Mobile Phone:**		
Email Address:					
Sex M F	**Date of Birth**	**Age**	Single Divorced Married Widowed	**Social Security #**	
Employer/School: Status: Full Time/part Time					
Employer:			**Occupation:**		
Business Address:			**Business Phone #**		
Spouse's Name:		**Spouse's Mobile #**		**Spouse's work #**	
Who to notify in case of an emergency (name and Phone #)					
Who referred you to the practice?					
Have you been known by a different name?					

MEDICAL INSURANCE (Please present your insurance card to be copied)		
Responsible Person for this account:	**Relationship to patient:**	
Subscriber's phone:	**Subscriber's birth date:**	**Subscribers Social Security #**
Primary Insurance:	**Insurance ID #**	**Group #**

Secondary Insurance:	Insurance ID #	Group #

I hereby authorize this physician's office to release any information necessary to secure payment of benefits. While we will assist with billing your insurance company, you are primarily responsible for determining what your insurance will cover, whether you require a referral and/or payment of your bill.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: ____ Date: ____________

Guardian Signature: ____

OVERLAKE FAMILY MEDICINE
HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records for your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- **Make sure that health information that identifies you are kept private**
- **Give you this Notice of our legal duties and privacy practices with respect to health information about you**
- **Follow the terms of the Notice that is currently in effect**

We may use and disclose health information about you:

- **For treatment**
- **For payment**
- **For health care operations**
- **For appointment reminders**
- **As required by Law**
- **To avert a serious threat to health and safety**
- **As required by the military or Veterans and Workers Compensation**
- **Public Health risks**
- **Health oversight activities**
- **Lawsuits and disputes**
- **Law enforcement**
- **Coroners, health examiners and funeral directors**
- **National and security and intelligence activities**
- **Protective services for the president and others**
- **Security officials for inmates**

Your rights regarding Health Information about you:

- **Right to inspect and copy**
- **Right to amend**
- **Right to an accounting of disclosures**
- **Right to require restrictions**
- **Right to request confidential communications**
- **Right to a paper copy of this notice**

Changes to this Notice:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the clinic administrator at our office to file a complaint.

Acknowledgement of receipt of this notice:
We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of the notice may change. If we change our notice, you may obtain a revised copy on our web site or by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to these restrictions, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.**
- **The patient has the right to revoke this consent in wiring at any time and all future disclosures will then cease.**

This consent signed by: ______________________ **Date:** __________________

Print Name: _________________________________

Relationship (If other than patient): ______________________________________

Witness: ____
(Practice representative)

CONSENT TO LEAVE MESSAGES

We at Overlake Family Medicine are working to insure the confidentiality regarding your Protected Health Information and care is maintained at all times. Due to confidentiality concerns and to comply with the HIPAA act of 1996, we need your signature to allow us to leave messages about your upcoming office visits, account information, and/ or any test results you may want us to convey to your via telephone or electronic messaging.

Please complete and sign this form, indicating your preference.

I ___________________________________ give Overlake Family Medicine permission to:

- **Leave a message regarding my upcoming office visit, Account information, and test results on my answering machine.** **YES / NO**
- **Leave a message at my home with someone who answers the phone at my residence.** **YES / NO**
- **Leave a message at my place of employment.** **YES / NO**

______________________________________ Date: _____________________
(Signature)

Relationship (if other than patient): ______________________________

Financial Policy and Consent Form

<u>*Overlake Family Medicine contracts with Washington Medical Billing, LLC to perform all Patient and insurance billing services.*</u>

1. **Payment is requested at the time of service; this includes but is not limited to co-payments, deductibles, and non-covered services. We accept cash, checks, Master card and Visa.**
2. **As a courtesy, we will bill your PRIMARY insurance for you and send any necessary reports to assist with reimbursement. We will bill you SECONDARY insurance for you as a courtesy.**
3. **All balances are due within 60 days of initial billing. SPECIAL NEEDS: Special needs are understood by this office. It may be necessary for you, please bring this to our attention as soon as possible.**
4. **Legal agreements between parents accepting or denying financial responsibility for medical bills are not recognized by this office. The parent who brings the child for medical care is responsible for the payment of services.**
5. **TO OUR MEDICARE PATIENTS: We are Medicare providers. Because of all the new laws and changes in allowed and no-covered services, we will bill Medicare for services rendered, however it is office policy to have all Medicare patients sign a waiver at each office visit that holds the patient responsible for any services that are non-covered.**
6. **A finance charge of 1% per month, up to 12% per years is applied on all accounts 60 days past due.**
7. **We will make every effort to expedite accurate claims to your insurance company for prompt reimbursement, but the agreement of the insurance company to pay for your medical care is a contract between you and the insurance company. The bill remains your responsibility.**
8. **USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION AND ASSIGNMENT: By signing on the line below this paragraph, you give consent for the doctor, Washington Medical Billing, L.L.C billing service and the insurance company to use and/ or disclose any personal health information required to process your medical claims, perform any required medical treatment or perform required administrative operations. You may refuse to give consent to use and/or disclose your personal health information for treatment, payment and operations, but in so doing, OVERLAKE FAMILY MEDICINE may refuse to provide you with treatment services. You have the right to revoke your consent in writing to the extent that the doctor, Washington Medical Billing, L.L.C billing Service Company and the insurance company have taken action in reliance on your original consent. Furthermore by signing on the line below you authorize your insurance benefits to be paid directly to OVERLAKE FAMILY MEDICINE.**

Please sign in the space provide to indicate that you understand the financial policy, use and disclosure of information, and assignment:

Signed: ________________________________ **Date:** ______________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Overlake Family Medicine's Notice of Privacy practices for review. I have also been informed that I can review this Notice of Privacy Practice at any time at www.overlakefamilymedicine.com. Overlake Family Medicine's Notice of Privacy Practice is also, posted in the lobby of clinic for review.

Name: ____

Date of Birth: _____________________

Signature: ____ **Date:** ____________________

Name: ____________________ Date of Birth: ____________

The new healthcare initiative required our staff to record the following information as part of your medical records. If you do not wish to answer the questions, you have the right to decline.

Race:

- € **American Indian or Alaskan Native**
- € **Asian**
- € **Black or African American**
- € **Native Hawaiian or other Pacific Islander**
- € **White**
- € **Other**
- € **Decline to answer**

Ethnicity:

- € **Hispanic or Latino**
- € **Non-Hispanic or Non-Latino**
- € **Decline**

Language:

- € **English**
- € **Chinese**
- € **German**
- € **Vietnamese**
- € **Korean**
- € **Japanese**
- € **Persian (Farsi)**
- € **Spanish**
- € **French**
- € **Portuguese**
- € **Italian**

- € **Filipino**
- € **Arabic**
- € **Other____________________________**

Thank you for your understanding, the staff at Overlake Family Medicine.