Eastside Integrated Primary Care

Today's Date____/____/____

Patient Registration Form

[Patient Info]

Patient Name_____Age_____
Last First Middle Name

Birthdate_____/_____/_____ Sex ☐M ☐F Martial Status ☐S ☐M ☐D ☐W
MM DD Year

Address_____
Street Apt/Unit City State Zip Code

Home # (___)_____ Cell # (___)_____ E-mail _____

Employer_____Phone(___)_____
Company Name Address

Perferred Pharmacy_____Phone(___)_____
Name Location

[Emergency Contact]

Name_____Age_____
Last First

Phone # (_____)_____ Relationship_____

[Accident/ Injury Info]

Are you being see today for an accident or injury? ☐Yes ☐No Date Of Accident _____

What type of accident? ☐ Auto ☐ Work ☐ Comp ☐ Slip/Fall ☐ Other Explain:_____

Have you seen elsewhere for this accident? Where ? _____

Do you have an attorney for this accident? ☐ Yes ☐ No

City and State where accident occurred ?_____

Attorney Name _____Phone(_____)_____

Address_____
Street Apt/Unit City State Zip Code

[Referral Info]

Who referred you to this clinic?_____
Name Phone# Relationship

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Eastside Integrated Primary Care

Name _____ **Today's Date** ____/____/____

Chief Concern

_____

_____

History of Present Illness

_____

_____

_____

Family History

	Brother	Sister	Father	Mother	Paternal Grandmother	Paternal Grandfather	Maternal Grandmother	Maternal Grandfather
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Colon Cancer/Polyps	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Stomach/Ulcer	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐

Other:

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Name_____ Today's Date ___/___/___

Past Medical History

- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Allergies/ Hay Fever
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Thyroid Disease
- ☐ Dizziness/Fainting
- ☐ Shortness of breath
- ☐ Esophageal Stricture
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Heart Palpitations
- ☐ Arrhythmia
- ☐ Othopnea
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Claudication
- ☐ Liver Disease/Hepatitis
- ☐ Chest Pain/Angina
- ☐ Other:_____
- ☐ Gi Disorder
- ☐ Kidney Disease
- ☐ Sexual Dysfunction
- ☐ Urinary Disorder
- ☐ Menstrual Dysfunction
- ☐ Venereal Disease
- ☐ Colon Polyps
- ☐ Stroke/TIA's
- ☐ Endocrine Disease
- ☐ Congenital Heart Disease
- ☐ Uclear
- ☐ COPD
- ☐ Anemia
- ☐ Anxiety
- ☐ Epilepsy
- ☐ Gout
- ☐ Gallbladde Issue
- ☐ Heart Attack
- ☐ Asthma
- ☐ Cancer

Hospitalization/ Surgery History/ Imaging

Reason for Surgery/ Hospitalization/ Imaging	Date(mm/dd/year)

Allergies

Current Medications:

Suppements:

Woman Only → Pregnant ☐ Yes ☐ No Planning Pregnancy ☐ Yes ☐ No

Social History

Relationship Status/ Living Situation: _____
Occupation: _____
Smoking History: Packs Daily _____
How Long? _____
Intrested in Stopping? _____
Caffeine: Type _____
Amount _____
Alcohol: Type _____
Amount _____
Recreational Drugs: _____
Diet: Restrictions _____
Typical BF, Lu, Dinner _____
Sleep: Difficulty Falling Asleep _____
Continualy Disturbance _____
Snoring _____
Early Morning Awakening _____
Daytime Drowsiness _____
Excesice Routine:_____

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Name_____ Today's Date ___/___/___

Review Of Systems- *Please Check any of the following that pertain to you:*

General
- o Recent weight gain/loss
- o Change of appetite
- o Sensitive to cold/hot
- o Cold sweats during day
- o Excessive daytime sweating
- o Sweating at night
- o Hot/Cold spells
- o Feeling tired or worn out
- o Sensitivity to heat
- o Excessive sleeping
- o Difficulty sleeping
- o Low resistance to infection
- o Flu-like or vague sick feeling
- o Other

Neurological
- o Forgotten period of time
- o Dizziness or vertigo
- o Drowsiness
- o Muscle spasms or tremors
- o Impaired ability to remember
- o Facial"tics"
- o Numbness/Tingling
- o Convusions/Fits
- o Slurred speech/Speech problems
- o Weakness in muscle
- o Suicidal thoughts
- o Memory problems
- o Difficulty planning/ Organizing
- o Behavior changes
- o Personality changes
- o Focusing/ Attention difficulty
- o Loss of motivation
- o Social phobias
- o Emotional changes
- o Emotionally volatile
- o Anxiety
- o Coordination problems
- o Drop things
- o Trip/ Bump into things
- o Abnormal skin sensation
- o Claustrophobic
- o Out of body expirences
- o Hear voices
- o See letters upside down or backwards
- o Paranoid
- o Obsessive, compulsive behaviors
- o Ideas pop in/out of head
- o Other

Respiratory
- o Asthma, wheezing
- o Cough
- o Coughing up blood/sputum
- o Shortness of breath
- o Rapid breathing
- o Repeated nose or chest cold
- o Other

Chesh & Cardiovascular
- o Ankle swelling
- o Rapid/ Irregular pulse
- o Breast tenderness
- o Chest pain
- o High blood pressure
- o Low blood pressure
- o Racing heart beat
- o Heart skips beats
- o Other

Head, Eye, Ear, Nose & Throat
- o Allergy symptoms
- o Headache
- o Head injury
- o Neck pain or stiffness
- o Frequent sore throat
- o Blurred vision
- o Double vision
- o Overly sensitive to light
- o See spots or shadows
- o Hearing loss in both ears
- o Ears ringing
- o Disturbance in smell
- o Runny/dry nose
- o Dry mouth
- o Sore tongue
- o Choke on food
- o Snore
- o Change in voice
- o Other

Gastrointestinal & Hepatic
- o Trouble swallowing
- o Nausea or vomiting
- o Abdominal pain (belly)
- o Anal Itching
- o Painful bowel movement
- o Constipation
- o Liquid bowel control
- o Loss of bowel control
- o Frequent belching or gas
- o Acid reflux
- o Rectal bleeding (red,black)
- o Change in appetite
- o Other

Musculoskeletal
- o Back pain or stiffness
- o Joint pain or stiffness
- o Bone pain
- o Leg pain
- o Muscle cramps or pain
- o Other

Skin, Hair
- o Dry hair or skin
- o Itchy skin or scalp
- o Easy bruising
- o Hair loss
- o Increased prespiration
- o Sun sensitivity
- o Other

Genitourinary
- o Itchy privates
- o Painful urniation
- o Excessive urination
- o Difficulty starting urination
- o Accidentally wetting self
- o Pus or blood in urine
- o Decreased sexual drive
- o Increase sexual drive
- o Erectile dysfunction in men
- o Other

Gynecology (Females)
- o Painful menstruation
- o Irregular menstruation
- o Menopausal symptoms
- o Pain with intercourse

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Primary Insurance Info

Insurance Carrier Name _____ Group Number _____

Patient's ID Number _____

Name of Insured_____ Relationship to Patient _____ Claim # _____

Insured Birthdate ____/____/____ Sex: ◯ Female ◯ Male

Insured Employer _____

Secondary Insurnace Info

Insurance Carrier Name _____ Group Number _____

Patient's ID Number _____

Name of Insured_____ Relationship to Patient _____ Claim # _____

Insured Birthdate ____/____/____ Sex: ◯ Female ◯ Male

Insured Employer _____

IN ORDER TO ACCURATELY BILL YOUR INSURANCE, THE ABOVE INFORMATION IS MANDATORY. A COPY OF YOUR INSURANCE CARD(S) IS ALSO REQUIRED.

Authorization To Treat

I hereby authorize the physician to render necessary and proper medical treatment deemed essential to my health care. I understand I have the right to refuse any and all procedures/services performed. If patient is a minorchild I hereby state I have legal authority to authorizee medical treatment and am hereby acknowledged that I am fully responsible for medical treatment and am hereby acknowledge that I am fully responsible for all medical expenses incurred, regardless as to any child support or to any other court order.

X_____ Date ____/____/____ Relationship to patient _____

Assignment & Release

I agree to pay for all medical services, should collection procedures become necessary. I understand I am responsible for any and all legal expenses including interest. I authorize the release of any medical information necessary to process my insurance claim. I also authorize payment to Dr. Amira Ahdut, PLLC direcly from my insurance company for services rendered. A copy of authorization shall be as valid as the original.

X_____ Date ____/____/____ Relationship to patient _____

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Eastside Integrated Primary Care

HIPPA CONSENT FORM

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE REVIEW CAREFULLY

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary we provide the minimum necessary information about treatment, payment or health care operations. These entities information are most often not required to obtain patient consent.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with out HIPPA Compliance Officer.

You have the right to review our privacy notive, to request restriction and revoke consent in writing after you have reviewed our privacy policy notice.

Date _____/_____/_____

I _____,_____ have received a copy of this file.
Print Name Sign Name

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Eastside Integrated Primary Care

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve this goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your behalf. If the insurance information is out-of-date, invalid, expired, or incorrect you will be responsible for payment which will be due immediately upon notice by Eastside Integrated Primary Care. If you would like us to rebill on your behalf, there will a $35 rebilling fee.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. These amounts are determined by your medical benefits, not by Eastside Integrated Primary Care.
3. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. Most plans cover naturopathic medicine, massage, and acupuncture in Washington State. However, some out of state plans, corporate plans, and Medicare do not cover these services; it is up to you to know if you have benefits for these services. If benefits are denied, you are responsible for payment in full. Coverage and benefits disputes should be addressed to your insurance company, not Eastside Integrated Primary Care office staff or physicians.
4. If our physicians do not participate in your insurance plan, we may submit an out-of-network claim on your behalf. You may be responsible for the balance due depending on your out-of network coverage. If you have trouble paying your balance you can contact us and request an out-of-network courtesy discount. We can almost always accommodate requests. However, these discounts are given on a caseby-case basis at Eastside Integrated Primary Care's discretion and require immediate payment after the discount is given.
5. For scheduled appointments, prior balances must be paid prior to the visit.
6. If you do not have insurance or if a service is not an insurance coverage. Payment for the service is to be paid at the time of the visit in order to qualify for our Time of Serviec case discount. Failure to pay will result in being billed the full list price.
7. Co-payments are due at time of service, if you forget we will let you know and charge your card on file.
8. Patient balances are billed every two weeks; after we receive your insurance plan's explanation of benefits we will bill your card on file.
9. If we cannot process your card on file. Late Fees are as follows: a. $25 fee if paper statements are required (no card on file, no response to email invoice) b. 3% monthly interest. c. 30% collections fee if referred to third-part collection service for failure to pay within 90 days.
10. We require 24-hour notice for canceling any appointments. There is a $75 charge for missed or canceled appointments if a 24-hour notice is not given. This will be billed to your card on file only after you have been notified (we often waive this fee for illness or emergencies).
11. A $45 fee will be charged for any checks returned for insufficient funds.
12. Not all services provided by our office are covered by every plan. Any service some, but not all, commonly requested services that are regularly not covered by insurance. If you request these services you will be billed or asked to pay at time of service.

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Service	Fee
Phone Consultations	Established Patient: $75.00 for the first 15 minutes, and $35.00 for every 15 minutes after that. New Patient: $180.00 for the first 15 minutes, and $35.00 for every 15 after that.
B12 + B Complex Injections	Single: $35 Package of Five:$118
Nutrient Iv Therapy	Will vary dependent on nutrients in bag or push.
Legal Paperwork, Letter, and Forms with No Appointment.	$15 for the first page, $10 per additional page.
Custom Prescription request with no appointment	$65
Expired prescription renewal with no appointment (may be denied if follow up is necessary)	No charge for electronic refill request or faxes sent through pharmacy. $35 if request made through office staff (phone or email)

EIPC Code of Conduct-

I will treat staff with courtesy and respect at all times. I understand that EIPC has a zero-tolerance policy regarding rude, vulgar, profane, or harassing comments or actions to any staff members.

Initial Here_____

Prescription Refill Policy-

To provide the best quality of care, EIPC adheres to a strict prescription refill policy. Please adress all medication refills at the time of your visit with your medical provider. If the refill is not done at the time of your follow up, please contact your pharmacist one week prior to needing your refill. Your pharmacist will fax us your request, please call your pharmacy to check on the status of your refill.

Some medications require a prior authorization. Depending on your Insurance this process may involve several steps by both your pharmacy and your provider. Your pharmacy will initiate this process this with EIPC. Your pharmacy will be notified of approval status first. Please check with them for updates on your request.

No refills will be given on Fridays, weekends, or holidays. Please allow three days minimum processing time for all requests. New symtoms and/or events require an office visit. No refills will be given for prescriptions no initiated by and EIPC provider.

Initial Here_____

I have read and understand this financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above. By signing below I am agreeing to all the terms and conditions as a patient at Eastside Integrated Primary Care:

Patient Name(s) _____

_____ _____

Responsible party member's signature **Date**

_____ _____

Responsible party member's name Relationship to Minor

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Eastside Integrated Primary Care

No more confusing medical bills, no more payment hassles, no need to send payment in the mail!

At Eastside Integrated Primary Care, we require keeping a credit pre-authorization on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable due to your deductible and coinsurance requirements. Your credit card information is kept confidential in a cloud-based portal installed and guaranteed to be secure by Stripe, a world leader in payment processing technology. We do not have access to your credit card number, only a standing payment authorization. Payments to your card are processed only after the claim has been filed and processed by your insurer and the insurance portion of the claim has first been paid and posted to the account. You will be notified by your insurance company in your Explanation of Benefits before you are charged. You will also be notified by email of charges made to your account. Please remember that Eastside Integrated Primary Care only charges what your insurance company tells us to charge you. If you disagree with a charge please first contact your insurance company and review your explanation of benefits.

I authorize Eastside Integrated Primary Care to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ Mastercard ☐ Discover

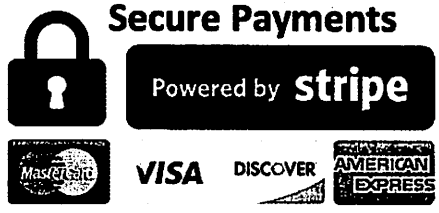
Last four digits of credit card* _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____



I, the undersigned, authorize and request Eastside Integrated Primary Care to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility or denies due to noncoverage. This authorization relates to all payments not covered by my insurance company for services provided to me by any healthcare provider at Eastside Integrated Primary Care. This authorization will remain in effect until I cancel this authorization. To cancel, I understand I must give a 60 day notification to Eastside Integrated Primary Care in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: ____ / ____ / ____

***Please hand card to receptionist for pre-authorization after handing in this form.**

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Eastside Integrated Primary Care

Frequently Asked Questions

Can I decline to keep a pre-authorization on file?

No, we will be phasing out our paper system completely as of 2018. Our goal is to get 100% of our patients enrolled into our new system. We would strongly prefer not to have to keep using two separate billing systems. If you have more concerns that have not been answered below, please do not hesitate to ask the front desk.

Why the switch? I like getting snail mail and sending checks.

We are going green! We send over a thousand statements per month, each averaging 2 pieces of paper and 1 envelope. That is one tree worth of paper every 3 months. Postage is pricey! Each statement costs about a dollar to process, stuff, and mail. By keeping costs low we can continue to offer our very reasonable cash prices, extended visit times, and higher wages for our excellent admin staff. People aren't paying their bills! Aside from the environmental and fiscal benefits, this decision was finalized when the amount of accounts that were3 months or more overdue exceeded 40%! Imagine you own a restaurant and 40% of the people who eat there take over 90 days to pay and 4% don't ever pay. Because of dramatic changes in healthcare policies many people now have very high deductible plans and are responsible for 100% of the first 5-10 thousand dollars' worth of care. Unfortunately, many people don't understand how high deductible plans work and are surprised that they have to pay anything...so they don't. Many clinics simply use collection agencies to keep this number down, but we prefer to keep things friendly.

What if I don't have a credit or debit card?

If you do not have a credit or debit card, a one-time billing fee of $25 will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, any outstanding balance charge of 3% percent of the total bill will be charged for each month that the bill remains unpaid.

What if I am only here to get treatment for a motor vehicle accident for which someone else is at fault?

You are still ultimately responsible for paying for the services you receive here. However, no charges will be made to your account until 90 days after your treatment has ended in order to give you time to settle your case.

What if I prefer to see the bill first then decide if I should pay? What if you or my insurance make a mistake?

Remember that you have already received the service and you have signed our Financial Policy Agreement stating you have checked your benefits prior to receiving service. Payment is not optional! Regardless if your card is on file or not, the same payment is due. If there was a mistake, we will gladly refund your money as soon as you get the issue resolved with your insurance company, and our billing specialists with help you every step of the way. Please remember that we accept insurance as a courtesy, at great expense to our clinic and sanity, and we only bill you what they tell us to. Any complaint about coverage should first be made to your insurer.

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