

Emerald City Medical Arts, PLLC
Patient Registration Form

Today's Date: _____ Referred by: _____

Patient Information:

Name: _____ Date of Birth: _____
(Last) (First) (M.I.)

Social Security #: _____ Sex: _____ Marital Status: S M D Partnered

Address: _____ Email ok for contact? Y N

City: _____ State: _____ Zip: _____ Email: _____

Phone: home: (_____) _____ work: (_____) _____

Employer: _____ Occupation: _____

Employer Address: _____

Spouse/Partner Information/Primary Insurer:

Name: _____ Date of Birth: _____

Social Security #: _____ Work Phone: _____

Employer: _____ Occupation: _____

Insurance Information (if you have a valid insurance card with you, please give it to us to scan into the system and skip the following section):

Primary Insurance: _____

Name of Insured: _____ Relation to patient: _____

Individual ID #: _____ Group #: _____ Insured's Employer: _____

Claims Billing Address: _____ CoPay? Y N Amount: \$ _____

Secondary Insurance: : _____

Name of Insured: _____ Relation to patient: _____

Individual ID #: _____ Group #: _____ Insured's Employer: _____

Claims Billing Address: _____ CoPay? Y N Amount: \$ _____

Emergency Contact: _____

Phone: _____ Relation to Patient: _____

Although services may be covered by insurance, I understand that: a) I am fully responsible for payment for care I receive; b) an administrative service charge of 12% or \$5.00 per month, whichever is greater, will be charged on all unpaid balances; and c) I will be charged \$50.00 for missed appointments or appointments cancelled or rescheduled with less than 24 hours notice. I authorize payment of medical benefits to my physician for services rendered. I authorize the physician or insurance company to release any information required for services rendered by this office.

Signed: _____ **Date:** _____

Emerald City Medical Arts Financial Agreement

Please read this information regarding the financial policies at Emerald City Medical Arts. The following points may help prevent you from being billed unnecessarily for charges that are not covered by your insurance plan or incurring additional administrative charges.

1. If your insurance, address or other contact information has changed, please let us know as soon as possible.
2. You are responsible for any charges that are incurred while you are here, whether or not you have insurance.
3. If you have a co-pay due, you must pay that amount on the day you are seen. Unless other arrangements have been made, there will be an additional charge of \$20 if we need to bill you for this.
4. If you plan to have Emerald City Medical Arts be your primary care facility and your plan requires you to select a physician, please make sure you select a provider in our practice prior to establishing care.
5. It is your responsibility to check with your insurance company before you arrive to determine whether your visit will be covered. If you have a question about your diagnosis on the day you are here, please check with your provider. Some plans do not cover certain diagnoses or procedures. Examples may include: Well care (yearly physicals), anything that is related to mental health (depression, anxiety, etc.), OMT (osteopathic manipulation), low testosterone, TMJ and acne.
6. If your insurance does cover the diagnoses listed above, there may be certain limitations associated with them. Please check to see if you have deductible, yearly cap, or higher co-pay for these services.
7. We do NOT accept secondary insurance, except for Medicare patients. If you are covered by more than one insurance plan, you will be responsible for your co-pay or co-insurance. We will happily provide you with a receipt for any money received – which you can submit to your secondary insurance for reimbursement.
8. If your insurance has expired and you are un-insured, please let us know as soon as possible. You will be responsible for payment on the date of service, though we do have a sliding scale for self-pay patients. If you neglect to inform us of your uninsured status, and we bill your insurance anyway – you will not receive the self-pay discount when the charge is transferred to your responsibility.
9. Patient balances that are over 45 days past due will be charged 12% interest or \$5 – whichever is higher.
10. If you pay by check and your check is returned for insufficient funds, there will be a charge of \$25 and possible interest for late payment in addition to the service fee added to your amount due.
11. There is a \$50 charge for missed appointments and for appointments that are re-scheduled with less than 24 hours notice.
12. Unless other arrangements have been made, any patient balances 90 days past due may be turned over to collections resulting in dismissal from the practice. If you are dismissed from the practice, you will not be able to re-establish care with Emerald City Medical Arts in the future.

By signing below, I acknowledge that I have read & understand the information above.

Patient Name (print) _____

Patient Name (signature)

Date

**ACKNOWLEDGEMENT
Of
PRIVACY PRACTICES**

Emerald City Medical Arts
16 Roy Street
Seattle, WA 98109
206-281-1616

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my medical provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

To: **Emerald City Medical Arts**

16 Roy Street
Seattle, WA 98109
Phone: 206 281-1616
FAX: 206 282-7371

I hereby authorize: _____
(Name of Provider or Organization)

Address

City, State Zip

(_____) _____ (_____) _____
Phone FAX

To disclose the following information from the health records of:

Patient Name: _____
(Last, First, Middle)

Previous Name: _____
(Last, First, Middle)

Address: _____

City: _____ State: _____ Zip _____

Telephone: (____) _____ Social Sec. # _____ -- _____ -- _____ DOB: ____/____/____

Information to be disclosed:

_____ All records pertaining to _____

_____ All medical records in your possession concerning health, illness and/or treatment.

_____ Recent lab test only _____ Immunization records only.

_____ Diagnostic Studies (Labs, X-ray, EKG, etc.)

If requesting birth records, include mother's name at time of birth: _____

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS or HIV Infection, alcohol and/or drug abuse and mental health conditions.

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization expires in 90 days.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

I understand that except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing health information to a third party, I am not required to sign this authorization in order to receive treatment.

The facility, its employees, officers, agents and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____
(Patient)

Date: _____

(or Legal Representative and Relationship)

Date: _____