Patient Registration Form (eCW)

PATIENT INFORMATION

(Please Print)

Patient's Name (Last)_____ (First) _____ (MI)____ Previous Name_____

Address _____

City, State _____ ZIP _____

Home Phone _____ Cell No. _____ Work Phone_____ Ext._____

Primary Care Provider (PCP) _____ Referred By_____

E-Mail Address _____

Date of Birth MM_____/DD_____/YYYY_____ Sex ☐ F-Female ☐ M-Male ☐ Transgender

Race☐American Indian/Alaska Native ☐Asian☐Native Hawaiian/Pacific Islander☐Black/African American☐White ☐Hispanic☐Other ☐Declined

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Language ☐English ☐Spanish ☐Indian ☐Japanese ☐Chinese ☐Korean ☐French ☐German ☐Russian ☐Other _____

Marital Status ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Partner

Employer Name_____

Employment Status ☐1 – Full-Time ☐2 – Part-Time ☐3 – Not Employed ☐4 – Self-Employed ☐5 – Retired ☐6 – Active Military

Student Status ☐F – Full-Time Student ☐P – Part-Time Student ☐N – Not a Student

Emergency Contact Last Name_____ First Name_____

Phone Number _____ Do you have a living will? ☐Yes ☐No

Emergency Contact Relationship to Patient _____ ☐Guardian

Home Phone _____ Work Phone_____ Ext._____

RESPONSIBLE PARTY INFORMATION

(information used for patient balance statements)

Responsible Party ☐Another Patient ☐Guarantor ☐Self **Check here if information is same as patient** ☐

Responsible Party Name (Last)_____ (First) _____ (MI)_____

Guarantor Account Number _____ Date of Birth MM_____/DD_____/YYYY_____

Social Security Number _____ Telephone _____

E-Mail Address _____ Sex ☐F - Female ☐M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____Group ID _____Copay Amount _____

Effective Date _____Termination Date _____ Date of Birth MM_____/DD_____ /YYYY_____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____Group ID _____Copay Amount _____

Effective Date _____Termination Date _____ Date of Birth MM_____/DD_____ /YYYY_____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Legal Guardian) Signature _____ ***Date***_____

PRACTICE/SCHEDULING POLICIES

OUR COMMITMENT TO YOU:

We are dedicated to providing high quality health care to our patients with compassion, integrity and professionalism. Our clinic works in partnership with our patients to improve the health of the community we serve. Our multi-generational and family approach to patient care emphasizes health education and preventative health care.

Please familiarize yourself with the policies below so we may better serve you. Don't hesitate to ask us if you have any questions.

- Please be on time for your appointment. 24 hour advance notice is requested to cancel your appointment, so we can make your appointment time available for other patients who need to be seen. Appointments not cancelled 24 hours in advance are subject to a cancellation fee. Missing more than three appointments without 24-hour advance notice may result in termination of the patient-provider relationship.
- If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule and the cancellation fee will apply.
- Balances due by patients under $5.00 will not be sent a statement due to cost; these balances will be collected from the patient at the next office visit.
- Please allow 3 BUSINESS DAYS for medication refills.
- Please allow up to 2 weeks for completion of administrative forms, i.e. School, Sports Physicals, Disability or FMLA forms. Some forms incur a fee for completion. You will be notified of any fees applicable prior to form completion. Complete all patient areas before turning in your forms.
- Patients are seen by appointment only. If you have an urgent need, please call us, we have Same Day Appointment available and will make every effort to accommodate you.
- Patients taking chronic pain medications are required to sign a narcotic agreement. This avoids confusion and ensures all refill requests are managed as smoothly as possible. Narcotics are NOT kept in the clinic. You are also subject to urine drug screens at your expense the day of your appointment as this is not a covered expense by insurance companies.
- The on-call physician does not refill controlled substances, including narcotics and sedatives, after hours.
- If you feel you require non-oral, narcotic pain medications, please proceed to the emergency room for evaluation and treatment.
- Adolescents have time alone with their doctor so they can freely communicate their healthcare concerns. We encourage open communication between family members and share your goal of encouraging your children to maintain healthy habits and responsible decision-making.
- There is an on-call provider available after hours for emergencies. Please feel free to contact our office during normal business hours for any non-emergency concerns or questions you have about your health. We are happy to address your concerns and schedule an appointment if one is needed.
- Abuse of the on-call system may subject you to additional charges.
- If you refuse an appointment at the advice of the triage RN, a tele visit charge will apply.
- Please schedule all well-child checks, sports physicals, and adult annual exams in advance of any deadlines to ensure an appointment is available.

Thank you for choosing us as your partners in health care! We appreciate the trust you've placed in us.

WELCOME TO THE CREEKSIDE FAMILY

Signature:_____Date: _____

ASSIGNMENT OF BENEFITS AGREEMENTS/FINANCIAL POLICIES

Our office will accept an assignment of benefits from your insurance company. It is important to understand, though, that the contract regarding your medical benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies...

- I authorize Creekside Medical to submit medical claims to my insurance company on my behalf. I understand that the submission of a claim does not absolve me of my responsibility to ensure a claim is paid in full.
- I authorize my insurance company to pay Creekside Medical directly for services/treatment I have received.
- I authorize Creekside Medical to submit appeals; if my insurance company denies me benefits to which I am entitled.
- I authorize Creekside Medical to furnish and/or release any information necessary to my insurance company regarding treatment I received.
- I understand it is my responsibility to provide Creekside Medical with current insurance information. Failure to do so will result in getting a bill.
- I understand my co-pay is due at time of service and I may not be seen if I do not pay.
- Patients under 18 years of age will be the responsibility of the parent bringing them in for treatment regardless of custody agreements.
- Any returned checks will be charged a fee of $40.
- Delinquent accounts will be charged a $20 late fee and are subject to collection action.

Print Patient's Name:_____ **Date:**_____

Patient or Legal Guardian' Signature:_____

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

By signing this form, I'm acknowledging receipt of the Notice of Privacy Practices of Creekside Medical.

Creekside Medical reserves the right to revise its Notice of Policy Practices at any time.

a copy of such revisions is available upon written request and can be found on the website

_____ _____

Signature of Patient or Legal Guardian Date

Laboratory Designation Form

Due to ever changing insurance contracts with various laboratories, we ask that you complete this form designating which lab you prefer to use. Ultimately it is your responsibility to know the benefits of your insurance plan. If you are not sure which laboratory your particular policy is contracted with, please call your insurance company before you leave the office today and let us know.

Example of services that require use of a lab:

- Phlebotomy – blood draws
- Strep Tests / Cultures
- Urine Tests / Cultures
- Pap Smears

Laboratory of Choice

☐ Quest
☐ Legacy
☐ Other: _____

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason. Charges for the lab tests are billed separately and not included in the charges for your physician visit. If you have questions or concerns about your lab bill, you must call the lab directly.

Patient Name: _____ DOB: _____

Signature: _____ DATE: _____

CREEKSIDE MEDICAL, PS

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Creekside Medical, PS** to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Creekside Medical, PS describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Creekside Medical, PS reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Jacque Hemmer, 900 NE 139th St, #202, Vancouver, WA 98685.

With this consent, **Creekside Medical, PS** will use the numbers below to text and/or leave a message on voice mail or in person referencing any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and clinical care, including laboratory rest results, etc.

Cell phone# _____ ( ) 1st Choice ( ) 2nd Choice / Text Enabled? ( ) Yes ( ) No

Home phone# _____ ( ) 1st Choice ( ) 2nd Choice

With this consent, **Creekside Medical, PS** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I hereby authorize Creekside Medical, PS to release PHI to the person(s) listed below:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I have the right to request that **Creekside Medical, PS** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Creekside Medical, PS** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Creekside Medical, PS** may decline to provide treatment to me.

_____	_____
Print Patient's Name	Date of Birth
_____	_____
Signature of patient or legacy Guarding	Date

_____
Print Name of Legal Guardian, if applicable

Patient Portal Authorization Form

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history and visitation dates
- Receive reminders through your email
- View current and past statements

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when your are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by a Creekside Medical Provider

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 10 failed log in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 8:00 am - 5:00 pm Monday-Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Patient Portal Authorization Form

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print patient's name: _____ DOB: _____

Patient or guardian signature: _____ Date: _____

Complete the following if the email address does not belong to the patient: (Please note, portal access is not available for patients aged 13-18 years).

Name of Parent/Guardian requesting access:

_____

Last Name Middle Initial First Name

_____

Relationship to the Patient Date

Our Patient Portal site may be accessed by two different URL's:

Our Website: www.creeksidemed.com

Patient Portal direct site: https://mycw20.eclinicalweb.com/portal1504/jsp/100mp/login.jsp

CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION

Patient's Name: _____ Date of Birth: _____

1. I understand that my health care provider, _____, wishes me to engage in a telemedicine consultation.

2. My health care provider's office has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. I understand that billing will occur for the telehealth visit.

7. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

_____ _____

Patient's/parent's/guardian's signature Date and Time

Permission for a Telemedicine Consult

How can telemedicine help you?

- You can stay closer to home.
- Your doctor may be able to start treatment sooner.

What could go wrong with telemedicine?

- The telemedicine system may not work as planned.
- The telemedicine system may break down.

What choices do you have?

- You can travel to the doctor to have an in-person visit.
- You can decide not to have the telemedicine visit.

What are your rights?

- You can stop the telemedicine visit at any time.

What are some common reasons for stopping a telemedicine visit?

- The telemedicine system is not working as planned.
- The telemedicine system breaks down.
- You are unhappy with using the telemedicine system.
- Your doctor is unhappy with using the telemedicine system.

Is your health information private?

- There are special safeguards to keep your information private.
- Only the people who are in your room and your doctor's office can see or hear you.

What must you doctor's office do before you sign this permission form?

- Answer your questions about using telemedicine.

What must you do before you sign this permission form?

- Make sure your doctor's office answers your questions about using telemedicine.
- Understand how telemedicine can help you.

_____ Initials

Authorization to Release Information

Creekside Medical

900 NE 139th Street, Suite 202 Vancouver, WA 98685
PHONE: 360-566-9355 **FAX:** 360-816-1327

Patient name: _____ Date of Birth: _____

Preferred name: _____ Parents' Names: _____ Phone: _____

Creekside Medical may

☐ **OBTAIN** my healthcare information from: **OR** ☐ **SEND** my healthcare information to:

Name or organization: _____

Email (Preferred): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I. Information to be disclosed or received: (check all that apply):

☐ Immunization Record(s)
☐ Most recent clinic note, date: _____
☐ All Progress Notes, Last 3 years
☐ EKG
☐ Laboratory Tests, Last 3 years
☐ Radiology / Imaging, Last 3 years
☐ Other: _____

***SENSITIVE RECORDS MAY REQUIRE PATIENT AUTHORIZATION.** Please initial all spaces of records **you want to obtain/send**. Records containing the following information require consent from the minor (items must be initialed to be released):

_____ Behavioral or Mental Health/ADHD & ADD (13 and older)
_____ Reproductive health care (all ages)
_____ HIV/AIDS (14 and older)
_____ Sexually Transmitted Disease (14 and older)
_____ Drug/alcohol abuse/diagnosis & treatment (13 and older)
_____ Genetic Testing

MINOR'S SIGNATURE: _____

Under Washington state law, minors may have the right to consent to certain types of care at certain ages, without parental consent, and in those cases, generally only the minor may authorize the use and disclosure of the related medical records.

II. Description of purpose of the use and/or disclosure:

☐ Transfer of Care / New PCP
☐ Consult / Specialist
☐ Insurance Claim
☐ Legal / Attorney Review
☐ Personal Use
☐ Other: _____

I authorize the transfer of my health care information to or from the above address. I understand that no charge will be made for transfer of information to another health care facility. However, if health care information is transferred to me, my family member, another person or third party such as an attorney or insurance company, the charge will be $25.00 plus $1.17 per page for the first 30 pages, and $0.88 per page after 30 pages. Payment is due before records are rendered.

III. My Rights

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand the person or organization that receives it may re-disclose it – privacy laws may no longer protect it. I may revoke this authorization in writing at any time. This authorization expires 90 days from the date it was signed.

_____ _____ _____

PATIENT'S SIGNATURE if 13 years or older* Date Time

_____ _____

PARENT OR LEGAL GUARDIAN SIGNATURE Relationship (parent or legal guardian)

Permission to use secure email: _____ (Patient/Guardian Initials) Email address: _____