Fremont Family Practice Registration Form

Name (first & last)	Preferred Name

Date of Birth (month/day/year)	Gender	Cell Phone Number	Home Phone Number

Address

City	State	Zip Code	Social Security Number

Occupation	Email	Marital Status

Person responsible for the bill if not patient	Relationship

Address

City	State	Zip Code	Phone Number

Insurance Information

	Primary Insurance	Secondary Insurance
Insurance Company		
Is it through an employer		
Subscriber Name (if not self)		
Subscriber date of birth		
Relation to Subscriber: child, spouse, other		
Member ID		
Group Number		

Referred to this office by:

Emergency Contact Information (of someone not living with you)

Name	Relation	Phone Number

I understand that I am financially responsible for all charges whether or not paid by insurance. Insurance coverage is not a guarantee of payment for services provided by my healthcare provider including preventative, routine screening, vaccinations, or procedures considered cosmetic in nature. It is my responsibility to understand my insurance benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. It is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance. Co-payments mandated by my insurance company may not be printed on my insurance card. I understand the co-payments are due at the time of service. It is my responsibility to notify thte receptionist upon arrival that a co-payment is due. A $20.00 handling fee will be added to my statement in circumstances when I have not paid at the time of service. I have been informed that NSFs for checks or credit card payments are subject to a $25.00 handling fee for each submission. A NO SHOW appointment without 24 hours advance notice is subject to a $40.00 fee. I have been informed that payment is due upon the receipt of my monthly statement. Should I have NO insurance, I understand that payment is due in full at the time of service.

Signature

Date

Rights and Responsibilities of the Patient

Fremont Family Practice has adopted the following rights and responsibilities for our patients.

As a patient of Fremont Family Practice you have the following rights:

1. The right to be treated with dignity and respect
2. That all comments and records will be treated with strict confidentiality. You will be given the opportunity to approve release of any information, consistent with the law.
3. The right to be provided with information concerning your diagnosis, treatment and prognosis.
4. The right to be given the opportunity to participate in decisions related to your health care
5. The right to informed consent previous to treatment except in case of emergency
6. The right to refuse treatment, you will be informed of the consequence of your actions.
7. The right to privacy.
8. The right to reasonable responsible service
9. The right to refuse to participate in experimental research.
10. The right to continuity of care.
11. The right to examine and to receive an explanation for your bill.
12. The right to report problems you may have concerning services received without fear of service being denied.
13. The right to services that will not be denied because of your race, sex, or nationality.
14. The right to examine our fee schedule.

As a patient of Fremont Family Practice you have the following responsibilities:

1. You are responsible for considerate and respectful treatment towards other patients and clinic personnel.
2. You are responsible for providing Fremont Family Practice with accurate and complete information regarding your present intake of medication and past medical information.
3. You are responsible for notifying Fremont Family Practice's staff when you do not understand the instructions given to you.
4. You are responsible for the consequences of refusing treatment or not complying with therapy, once the consequences have been explained to you.
5. You are responsible for keeping appointments, complying with therapy and following treatment.
6. You are responsible for being on time for your appointments and providing us with the documentation necessary to assist in determining your payment status.
7. You are responsible for fulfilling your financial obligations.

Signed: _____ Date: _____

Patient consent form

Patient Consent for Use and Disclosure of Protected Health Information

- I hereby give my consent for Fremont Family Practice 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 can be provided by Fremont Family Practice and describes such uses and disclosures more completely.)
- I have the right to review the Notice of Privacy Practices prior to signing this consent. Fremont Family Practice 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 <Dr. David Harvey Fremont Family Practice, 4464 Fremont Ave N Seattle, WA 98103>
- With this consent, Fremont Family Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including lab results, among other things.
- With this consent, Fremont Family Practice 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 as long as they are marked “Personal and Confidential.”
- With this consent, Fremont Family Practice may email to me any items that assist in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Fremont Family Practice restrict how it uses or discloses my PHI to carry out TPO
- The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- By signing this form, I am consenting to allow Fremont Family Practice to use and disclose my PHI to carry out TPO. I also acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Fremont Family Practice.
- 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, Fremont Family Practice may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Print Patient’s name Print name of Legal Guardian, If applicable

Fremont Family Practice Payment Policy

Thank you for choosing Fremont Family Practice as your primary care clinic. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-todate insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some and perhaps all of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You are responsible to pay for these services.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We will make a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.

8. Missed appointments. Our policy is to charge for missed appointments not canceled within a 24 hour period. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date