GREENLAKE PRIMARY CARE
NEW PATIENT INFORMATION

Patient's Legal Name:_____
First Middle Last

Name you like to be called_____

Gender you would like to be referred to as: Male (he)/Female (she)/Other (they/them)

Social Security #_____-_____-_____ Birth Date_____ (Mo/Day/Yr)

Address _____
Street/ P.O. Box (Apt #) City State Zip Code

Billing Address (if different)

_____
Street/ P.O Box (Apt #) City State Zip Code

Home Phone # (___)_____Cell #(____)_____
Employer_____
Occupation_____ Work Phone (_____)_____

Permission to leave messages on which phone number, if any?_____

Email address:_____

Family Status:
Single Married Partnered Widowed Separated Divorced

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____
(Name and Relationship to patient)
Address_____
_____
City State Zip

Home/Cell Phone # (_____)_____ Work # (_____)_____

Med Power of Attorney:_____Phone#_____

With whom may we discuss your care?
_____
_____

BILLING INFORMATION

Who is responsible for the bill? (circle one) Self Partner Spouse POA Parent Other
Name:_____
Address & Phone # (if different than above) _____
_____

INSURANCE INFORMATION

Primary insurance_____
Preferred Plan (PPO): Yes No (Please provide card to receptionist for a photo copy)
Name of Subscriber (Who has the insurance?): _____
Soc. Sec # _____ Date of Birth _____ Co-pay: Yes No
Individual ID #:_____ Group # and/or Name:_____

Secondary insurance _____
Preferred Plan (PPO): Yes No (Please provide card to receptionist for a photo copy)
Name of Subscriber (Who has the insurance?): _____
Soc. Sec # _____ Date of Birth _____ Co-pay: Yes No
Individual ID #:_____ Group # and/or Name:_____
Photo copies of insurance cards go here Consent for Care:

I give permission and authorize the providers and staff of Greenlake Primary Care to examine and treat me. Insurance Release of Benefits and Information: I authorize insurance benefits to be paid directly to the provider or clinic. I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my insurance plan. I authorize the providers or insurance company to release any information required for processing of insurance claims.

This authorization is in effect until rescinded in writing.

Signature of Patient/Guardian:_____Date: _____

Patient's name:_____

Greenlake Primary Care Financial Policy (updated 9/2016)

Greenlake Primary Care participates with a wide variety of insurance plans including: Aetna, Cigna, First Choice, Labor & Industry, Medicare, Premera, Regence, Tri Care, Uniform, United Healthcare, and others. We do not bill third party for motor vehicle accidents.

Know your insurance plan. Before your visit, call the toll free number on the back of your insurance card. Make sure you know if we are assigned as your primary care provider.

- Ask your insurance representative if the practitioner you wish to see is a preferred provider.
- Then please designate her as your primary provider.
- You may also ask whether you need a written referral to specialists, how often this needs to be renewed, and review your coverage, deductible, co-payment, and benefit limits.

Then:

- Bring your insurance card to **every visit**.
- Tell us if your insurance or mailing address has changed.
- Pay your co-pay at the time of your visit.

Greenlake Primary Care will submit your bill to your insurance company for you.

If you do not have medical insurance, it is your responsibility to make full payment at the time of your visit for the services given. If there is financial hardship, please let us know.

Please note:

- For your convenience we accept both Visa and Master Card.
- Checks returned for insufficient funds will result in an immediate charge of $35.00 against your account.
- There may be a charge of $50.00 for no shows or late cancelations (less than 24 hours in advance)

Questions about your account can be answered by **Physician Billing Partners at (206) 932-9025**

Financial Responsibility, Release of Insurance Benefits, Release of Health Information to Insurer:
I authorize Greenlake Primary Care to request and directly collect, on my behalf, all public and private insurance coverage benefits due for products and services provided by Greenlake Primary Care. I authorize Greenlake Primary Care, to release any health care information necessary to facilitate the processing of claims and audit of payments, for the services provided to me or my child by Greenlake Primary Care. The authorization is in effect until rescinded in writing.
If insurance benefits are paid directly to me, I will endorse these checks for such payments to Greenlake Primary Care. **I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my insurance plan.**

I have read and understand this policy. A copy will be kept in my chart and a copy may be furnished to me at my request.

Print patient name _____ Date Birth_____

Signed: _____ Date:_____

Guardian if minor:
Signed: _____ Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
NFB, PLLC d/b/a GREENLAKE PRIMARY CARE and GREENLAKE PSYCHIATRIC

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), as updated by the 2013 HIPAA Final Omnibus Rule.

In summary under HIPAA, I understand that my personal information may be used to:

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

I have been informed of Greenlake Primary Care (GPC) and Greenlake Psychiatric's Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use.

I understand that GPC and Greenlake Psychiatric have the right to change their Notice of Privacy Practices and that I may contact this office to obtain a current copy.

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.

I further understand that GPC and Greenlake Psychiatric are not required to accept my requested restrictions, but if they are accepted then I understand that they will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at GPC and/or Greenlake Psychiatric.

Our Notice of Privacy Practices describes in more detail how your health care record may be used and disclosed, and how you can access your information. Copies are available at our office or on our website: www.greenlakeprimarycare.com.

I acknowledge that I have had the opportunity to review the Notice of Privacy Practices. This signed acknowledgement form of my review will be retained in my medical record, in accordance with HIPAA Privacy Act regulations.

_____/_____/_____/_____ Signature
Today's Date Printed Patient Name Date of Birth

For Minor Guardian signature

_____/_____/_____/_____ Signature
Today's Date Printed Patient Name Date of Birth

Authorization to Communicate Protected Health Information

Check all that apply and insert phone number:

GPC and Greenlake Psychiatric may leave a detailed message on voicemail:
_____ at my home #: (_____) _____
_____ at my cell #: (_____) _____

GPC and Greenlake Psychiatric may speak with another person (spouse, family member) about my medical condition (**circle**) including / excluding information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine:
Name/Relation: _____ Phone #: (_____) _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record according to and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify GPC and Greenlake Psychiatric should I change one or more of the telephone numbers listed above.

_____/_____/_____/_____ Signature
Today's Date Printed Patient Name Date of Birth

For Minor Guardian signature

_____/_____/_____/_____
Signature Today's Date Printed Patient Name Date of Birth

For administrative use only:
We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:
Patient declined to sign:_____
Emergency situation:_____
Communication barriers:_____
Other: _____

Staff name/date/signature:_____

Greenlake Primary Care

6800 E Green Lake Way N, #200 Seattle, WA 98115 Phone (206) 524-5656 Fax (206) 524-2841

New Patient Medical History – Please complete this two-sided form prior to your first appointment.
Name: _____ Date of Birth: ____/_____/_____ Age: _____ Sex: ____

Please briefly state the reason for your visit in the box below.

Past Medical History

Condition / Disease	Year Began	Condition / Disease	Year Began

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures

Operation / Hospitalization / Injury	Month / Yr	Operation / Hospitalization / Injury	Month / Yr

Medication or Food Allergies or Intolerances

List below medications or foods causing an allergic reaction (i.e. rash, swelling) or intolerance (i.e. nausea)

Medication / Food	Reaction	Medication / Food	Reaction

Medications, Vitamins, and Herbal Supplements

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency

Disease Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests

	Month / Yr		Month / Yr		Month / Yr
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Abd Aneurysm Screen	
HPV Vaccine		Chest X-Ray		HIV Test	

Family Health History

Please list below the health history of your blood (genetic) first degree relatives.

Relative	Living or deceased	Current age or age at death	Cause of death	Health problems
Father:				
Mother:				
Brother(s):				
Sister(s):				

Social, Educational, and Work History

Marital Status: Age of children, if any:
Work Status (circle one): Employed, Unemployed, Retired, Disabled
Highest level of education: Current or prior occupation:
What type of exercises do you perform, duration, and frequency?
What are your hobbies?
Have you a current smoker? What age did you start? How many packs per day?
Are you a former smoker? What year did you quit? No. of years you smoked?
How much alcohol do you drink per day? Per week? What type?
Have you ever used recreational drugs? If yes, which ones?
Are you sexually active? Yes / No Do you have sex with Men / Women / Both?
Are you concerned that you may have been exposed to HIV? Yes / No
Do you feel safe in your relationships?

Review of Systems

In the past 2 weeks: Have you been feeling down, depressed, or hopeless? YES / NO

In the past 2 weeks: Do you have little interest or pleasure in doing things? YES / NO

Please review the following symptoms and circle those items that are a problem for you.

Vision problems	Chest pain	Blood in urine	Fainting
Hearing problems	Shortness of breath	History of STD's	Seizures, Tremor
Sinus trouble	High blood pressure	Anemia	Headaches
Hay fever	Lump in breast	Easy bruising	Numbness / tingling
Nosebleeds	Breast /nipple discharge	Pain in legs	Anxiety / Depression
Sore throat	Trouble swallowing	Pain in back	Difficulty Sleeping
Hoarseness	Nausea, vomiting	Joint pain / stiffness	FOR WOMEN ONLY
Lump in neck	Diarrhea	Blood clot	# pregnancies, # births
Tooth problems	Constipation	Weight loss / gain	Irregular, heavy, painful periods
Cough	Blood in stool	Heat / cold intolerance	Days of flow _____
Coughing blood	Abdominal pain	Excessive hunger / thirst	Age of onset _____
Wheezing, Asthma	Hepatitis / Jaundice	Weakness	Age at menopause_____
COPD, Emphysema	Frequent Urination	Fatigue	Hot Flashes
TB exposure	Incontinence	Fever / Night sweats	Abnormal Pap

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