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 # (_____)_____

If Applicable Medical 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This authorization is in effect until rescinded in writing.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_____

Patient Signature: _____ Date: _____

Guardian if minor:_____ 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 Pediatric History Form

Name: _____ DOB: _____ Age: _____

Form completed by: _____ Date: _____

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth Date	Health problems	Occupation

What is child's living situation if not with both biological parents?

Birth History

Birth weight _____ Was baby born at term? ☐ Yes ☐ No If not, how early? _____

Was delivery ☐ Vaginal ☐Cesarean

Were there any complications with the pregnancy or birth?

_____

During pregnancy, did mother: Use tobacco? ☐ Yes ☐No Drink Alcohol? ☐ Yes ☐No

Use drugs or medications? ☐ Yes ☐ No If Yes, please explain

_____

How was baby fed? ☐ Formula ☐Breast milk If breastfed, how long? _____

General

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No

If yes, explain

_____

_____

Has your child had any surgery? ☐ Yes ☐ No

Explain_____

_____

Has your child ever been hospitalized? ☐ Yes ☐ No

Explain_____

Is your child allergic to any medications or food? ☐ Yes ☐ No

If yes,

explain_____

Does your child take any medications? ☐Yes ☐ No

If yes, please list medications, dose, and frequency.

_____

_____

_____

_____

Are there cultural or religious practices that might affect your child's medical care?

☐Yes ☐ No

If yes, please explain (i.e.: blood transfusion, dietary rules, etc.):

_____

Do you have any concerns about your child's development? ☐ Yes ☐ No

If yes, please explain

_____

At what age did your child:

Sit alone _____Walk alone _____Say words _____Toilet train (daytime) _____

Girls only: Age at first menstrual period _____

Do you have any concerns about your child's diet? Yes No

Milk intake now: Type: ☐ Cow's milk (nonfat, 1%, 2%, Whole) ☐ Soy milk ☐ Rice milk ☐ Other

Average cups per day: _____

Safety

Do you have any concerns about your child's behavior? ☐Yes ☐ No

If yes, please explain

_____

_____

Has child been seen by a dentist? ☐Yes ☐ No If yes, Date of last visit _____

Do any household members smoke? ☐ Yes ☐ No

When your child is in the car does he/she use: ☐Car-seat: ☐Rear-facing ☐Forward Facing ☐Booster seat ☐Seat belt

Does your child use a bicycle helmet? ☐ Yes ☐ No

TV hours per day _____ Computer hours per day _____ Video game hours per day _____

Are there guns in the home? ☐Yes ☐ No

School History:

Does your child attend school or preschool? ☐ Yes ☐ No

Current grade _____ Name of school

_____

Any concerns about school?

_____

Does your child have an IEP or 504 plan? ☐ Yes ☐ No

Sports / exercise: Type _____, How often?

_____

Review of Systems: Please circle any current problems your child has on the list below:

Fevers, chills	Nausea / vomiting	Clumsiness
Excessive sweating	Diarrhea	Speech problems
Squinting / crossed eyes	Constipation	Anxiety / stress
Unusually loud voice	Blood in bowel movement	Problems with sleep / nightmares
Hard of hearing	Bedwetting	Depression
Mouth breathing / snoring	Pain with urination	Nail biting / thumb sucking
Bad breath	Penile or vaginal discharge	Bad temper / breath holding / jealousy
Frequent runny nose	Muscle / joint pain	Unexplained lumps
Problem with teeth / gums	Rashes	Easy bruising / bleeding
Tires easily with exercise	Unusual moles	Chest pain
Shortness of breath	Birthmarks	Weakness
Fainting	Hay fever / itchy eyes	
Cough / wheeze	Headaches	

Other information you would like us to know: