GREENLAKE PRIMARY CARE
PATIENT INFORMATION

Patient's Legal Name: _____
First Middle Last
Name you like to be called_____
Gender:_____ Gender (legal):_____ Gender assigned at birth:_____
Pronouns: he/him, she/her, they/them or _____

Ethnicity (required by Medicare, Vaccine Program, and insurance companies) circle one:

American Indian	African American	Native Hawaiian or Pacific Islander
Hispanic/Latino	Non-Hispanic/Latino	White
Asian	Declined to specify	

Preferred Language:_____

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 #(____)_____

Permission to leave messages on which phone number? _____

Email address: _____
(Please sign email waiver)

EMERGENCY CONTACT INFORMATION

Emergency Contact/next of kin: _____
(Name and Relationship to patient)
Address_____
City State Zip

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

<u>Guardianship:</u>
If applicable, who has legal guardianship over the patient? Please list name and phone number.

_____

<u>With whom may we discuss your care</u>?
_____
_____

BILLING INFORMATION
INSURANCE INFORMATION

Primary insurance_____

Secondary insurance _____

Insurance card copied by front desk.

If you are **not** the primary insured please fill in the following information:

Guarantor Primary Insurance
Name:_____
Relationship to patient:
Address_____
City State Zip
Home/Cell Phone # (_____)_____ Work # (_____)_____
Date of birth:_____ Social Security Number:_____

Guarantor Secondary Insurance
Name:_____
Relationship to patient:
Address_____
City State Zip
Home/Cell Phone # (_____)_____ Work # (_____)_____
Date of birth:_____ Social Security Number:_____

Please make sure to bring a copy of your cards to each visit to avoid incurring a bill for services.
If this is for a child – please list the parents' names and Date of birth. **The parent with the first birth month (i.e. January vs February) will be considered "primary insurance" holder for all doubly covered children**.

CONSENT TO BE TREATED:

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 9/2019)

Greenlake Primary Care participates with a wide variety of insurance plans including: Aetna, Cigna, First Choice, Labor & Industry, Medicare, Premera, Regence, Uniform, United Healthcare, and others. We **do not bill third party** for motor vehicle accidents. We **do not take EPO plans or HMO plans. We no longer contract with Tricare.**

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/him 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 will be a charge of **$50.00** for no shows or late cancelations (less than 24 hours in advance) for primary care appointments and $**175** for psychiatric appointments.

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_____

Signature: _____ Today's date: _____
(if guardian's signature please print your name here: _____)

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.
I also acknowledge that GPC and Greenlake Psychiatric will call to leave reminder phone calls with date and time, name of provider; on occasion reminder post cards may be sent as well.

Name of patient: _____ Date of Birth: _____

Signature: _____ Today's date: _____
(if guardian's signature please print your name here: _____)

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.

Name of patient: _____ Date of Birth: _____

Signature: _____ Today's date: _____
(if guardian's signature please print your name here: _____)

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:_____

HIPAA Email Consent

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information and updated in 2013
- Personal Information is not stored on our computers
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do **not** encrypt email
- When we send you an email, or you send us an email, the information that is sent is **not necessarily encrypted**. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for many people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website. http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email
- Email sent from Practice Fusion/Patient Fusion/Zocdoc is NOT initiated by Greenlake Primary Care this includes all patient satisfaction surveys. If you do not wish to receive emails from these entities, please contact them directly.
- When you initiate an email to our office, you are accepting the risk of sending unencrypted health information and thereby waiving your right to privacy in that instance.

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Greenlake Primary Care to send personal health information via unencrypted email to me; they may also communicate via email with my specialists and other outside providers as indicated by me through a signed release of information form.

Signature:_____ Date: _____

Name: _____ (please indicate if you the patient or guardian of a minor)

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to allow personal health information via email.

Signature:_____ Date: _____

Name: _____ (please indicate if you the patient or guardian of a minor)

Greenlake Primary Care

Telemedicine Consent Form

Patient Name:_____Date of Birth:_____

Permanent Address:_____

Cell phone_____ Home phone:_____

As a patient of Greenlake Primary Care, I understand it is possible that at some point in my treatment, services will be provided via Telemedicine. I understand and agree to the following with respect to use of Greenlake Primary Care's telemedicine program.

1. I understand that telemedicine is provided via secure interactive audio and video technology such as via doxy.me, Zoom for Healthcare, Microsoft bookings, and during the COVID crisis (March 1 2020 through December 31, 2020) FaceTime, while the provider is in a different location than me.
2. I understand that this service may involve but is not limited to gathering of health data, and treatment via interactive audio and video. These sessions will not be recorded. The laws that protect the confidentiality of my health information apply to these services the same as in-person services. The information is, therefore, generally confidential except when the law mandates reporting.
3. I understand that there is the risk of the recording be disrupted or distorted by technical failure and/or the transmission of my health information could be intercepted or accessed by unauthorized persons. I understand that my own device and internet connectivity may impact the quality of the services and that Greenlake Primary Care does not have any control over my end of the transmission. Despite these risks, I agree that telemedicine services are appropriate.
4. I understand that telemedicine services may not be the same as in-person services, where non-verbal communication (body signals) and physical exam are readily available to both the provider and me. I understand that if my provider believes I would be better served by in person services, I may be referred to come into the clinic at Greenlake Primary Care or referred for care at another location.
5. If our telemedicine appointment abruptly ends, the provider will immediately call me at the number(s) listed above. together we will either attempt to continue the appointment or reschedule.

I have read and understand the information provided above. If I have any questions I can ask my provider at the time of visit or the front desk at the time of scheduling. I hereby consent to participate in the telemedicine services.

Patient name:_____ Date _____

Guardian if needed: _____

HHS Relaxes Telehealth HIPAA Rules, Allows for Video Chat

The Health and Human Services (HHS) Office for Civil Right (OCR) has announced that it is relaxing HIPAA rules for physicians and other health care providers using telehealth in response to COVID-19. This change is effective immediately. According to OCR, the agency "…will waive potential HIPAA penalties for good faith use of telehealth during the nationwide public health emergency due to COVID-19." The OCR has offered additional guidance:

A covered physician or health care provider *that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency* ***can use any non-public facing remote communication product that is available to communicate with patients****. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.*

For example, a covered physician or provider in the exercise of their professional judgement may request to examine a patient exhibiting COVID- 19 symptoms using a video chat application connecting the physician's or patient's phone or desktop computer to assess a greater number of patients while limiting the risk of infection of other persons who would be exposed from an in-person consultation. Likewise, a covered physician or health care provider may provide similar telehealth services in the exercise of their professional judgment to assess or treat any other medical condition, even if not related to COVID-19, such as a sprained ankle, dental consultation, or psychological evaluation, or other conditions.

Under this notice, covered physicians and providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. *Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.*

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.