Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:

First Name:

Middle Name:

Address:

City: State:

Zip:

Home Phone:

Work Phone:

Mobile Phone:

Sex:

Date of Birth:

Patient email:

Required by government mandate [although you may refuse]:

Language:

Race:

Ethnicity:

Marital Status:

GUARANTOR INFORMATION (TO WHOM STATEMENTS ARE SENT)

Name:

Address:

Relationship to patient: _____

Date of Birth:

Phone: ( ) _____ - _____

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Phone:

EMPLOYER INFORMATION

Employer:

Address:

Phone:

PHARMACY INFORMATION:

Name:

Location (Street/City):

PRIMARY INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policyholder:	Patient's relationship to policyholder:

I authorize HARKNESS MEDICAL GROUP, PLLC to contact me by email, home or mobile phone (call or text). To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

412 Black Hills LN SW #A
Olympia, WA 98502

Harkness Medical Group, PLLC

Office: 360-995-4219
Fax: 360-562-0635

Patient Intake Health History Form

Name: **Date:**

Allergies: Food or medication (please list)

1. 4.
2. 5.
3. 6.

Medication: (name, dosage, how often you take them; please include supplements/herbs)

1. 5.
2. 6.
3. 7.
4. 8.

Past surgeries and date:

1. 3.
2. 4.

Family History:

Mother: Alive (yes / no) Medical conditions:

Father: Alive (yes / no) Medical conditions:

Siblings medical conditions (please indicate which sibling):

Social History:

Smoke: (yes / no) If yes, age started: how much do you smoke/day: Have you quit: (yes / no)

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Do you drink alcohol: (yes / no) How much/often?

What do you drink? (hard alcohol / wine / beer)

Screenings:

Last colonoscopy: Were polyps removed? (yes / no)

Last bone density scan:

Female:

Last mammogram: Ever have abnormal colonoscopy results?

Last pap smear: Ever have abnormal pap smear results?

First day of last period:

Sexually active? (yes / no) Birth control method?

Possibility of pregnancy (yes / no)

ACKNOWLEDGEMENT AND AUTHORIZATION:

HARKNESS MEDICAL GROUP, PLLC follows all State and HIPAA/Privacy Laws. Protected patient information will not be given out unless required to by law or from direct consent from the patient. HIPAA/Privacy Laws are available for review as requested.

AUTHORIZATION TO GIVE MEDICAL CARE – CONSENT TO TREATMENT:
I hereby voluntarily consent to outpatient care from the HARKNESS MEDICAL GROUP, PLLC encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work and administration of medications as prescribed by the Providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by the HARKNESS MEDICAL GROUP's medical Providers and staff, as is necessary in the medical staff's judgment. I understand that during the course of treatment, health care workers may be exposed to the patients' blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker. I understand that this consent will be valid and remain in effect as long as I attend the clinic.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the HARKNESS MEDICAL GROUP, PLLC to release any information acquired in the course of my examination and treatment to any authorized agent for the purposes of healthcare, treatment, and payment. I authorize the release of medical information to my insurers as necessary for determination and payment of benefits; to healthcare providers involved in my care; to utilization review and professional standards review organizations, companies, and community resources that assist me with my healthcare needs.
.
AUTHORIZATION TO ACCESS MEDICATION HISTORY INFORMATION: I authorize HARKNESS MEDICAL GROUP, PLLC to obtain/have access to my medication history. As part of a healthy Provider/Patient relationship, medication history access will allow my provider to give the highest quality of care when determining the best course of action for any procedure(s) and/or treatment(s).

ACKNOWLEDGEMENT OF PERSONAL PROPERTY: I understand that HARKNESS MEDICAL GROUP, PLLC shall not be liable for loss or damages of any personal property.

FINANCIAL POLICIES:
I authorize the HARKNESS MEDICAL GROUP, PLLC to file a claim with my insurance carrier for services rendered.
I hereby assign my insurance benefits and authorize payment to be made directly to HARKNESS MEDICAL GROUP, PLLC. **ANY ENCOUNTERS, PROCEDURES, OR TREATMENTS THAT ARE NOT COVERED UNDER MY MEDICAL INSURANCE FOR ANY REASON WILL BE PATIENT RESPONSIBILITY.** I understand that insurance is a contract between myself and my insurance carrier. HARKNESS MEDICAL GROUP Is not a party to this contract. We will bill your insurance carrier as a courtesy to you. In order to properly bill your insurance carrier we require that you disclose all insurance information including primary and secondary insurance cards, as well as any change of insurance information within 10 days of service. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of your eligibility and benefits. It is your responsibility to determine if your insurance company is contracted with us. If your insurance carrier is not contracted with us, you are responsible to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If your insurance carrier pays you directly rather than the clinic, you are responsible for payment and agree to forward the payment to us immediately. All copayments, coinsurances, and deductibles may apply. Copayments are the patient's responsibility and are due at the time services are rendered. If you are uninsured, please note that your account is your responsibility. The parent or legal guardian of a minor patient (under 18 years of age) is responsible for payment on the minor's account. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age or older and receiving treatment, you are ultimately

responsible for payment of the service. Our office will not bill any other personal party. I understand that diagnostic services (i.e. laboratory tests and diagnostic images such as X-ray, CT, US, and MRI) are billed separately by the rendering facilities and therefore are not included in our charges. Any questions regarding bills from these outside entities will need to be directed to the billing departments of the company where services were rendered. I understand that if no extenuating circumstances apply, if my bill reaches a balance greater than **TWO** office visits, services can be denied until the account is brought to current. I understand that should any circumstances occur, I can contact HARKNESS MEDICAL GROUP, PLLC to resolve any billing issues.

NO SHOW POLICY:
If I am not able to keep an appointment I will contact the office 24 hours prior to my appointment time to cancel or reschedule. If I miss an appointment without notifying the office within this time frame or if I fail to cancel my appointment before/at the 24 hour deadline, I acknowledge that I will be charged a $45 no show/late cancellation fee. If I am 10 minutes late to my appointment, I will be asked to reschedule and will be charged a $45 no show fee. Should I reach three no shows within a 12 month period, I could be dismissed from the practice.

HARASSMENT POLICY:
I will remain respectful and appropriate with members of the HARKNESS MEDICAL GROUP team. Any disrespectful behavior or verbal abuse will not be tolerated and could lead to my dismissal from the practice.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING; EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE THEREOF. I ALSO UNDERSTAND THAT BY REFUSING TO SIGN THIS CONSENT OR REVOKING THIS CONSENT, THIS ORGANIZATION MAY REFUSE TO TREAT ME.

My signature below indicates that I understand and accept the content of this form.

Signature _____ Date & Time _____AM/PM
Patient or Patient Representative

Print Name_____ Date of Birth_____

If not the patient: Relationship to Patient _____

Witness_____ Date _____ Time _____AM/PM

Consent to Disclose Health Information

Patient name: **DOB:**

_____

I hereby authorize Harkness Medical Group to disclose the following information from the health records of the patient listed above to the individual indicated below.

From (date) _____ to (date) _____

General information to be disclosed:

_____ Health care information relating to the following treatment, condition, or dates of treatment: _____

_____ All Health Care information (Personal Health Information)

_____ Other: _____

This information is allowed to be disclosed to (Name of Person/s):

_____.

(NAME OF PERSON YOU WISH TO HAVE ACCESS TO YOUR HEALTHCARE INFORMATION)

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, I herby release the facility, its employees, and providers from any legal responsibility or liability for disclosure of all healthcare information relating to such diagnosis, testing, or treatment.

_____

Patient/Representative Signature: _____

Printed Name: _____

Date: _____

RECORDS RELEASE

Patient name: _____ **DOB:** _____

I hereby authorize _____ to disclose the following information
(Previous provider's office name)
from the health records of the patient listed above.

From (date) _____ to (date) _____

General information to be disclosed:

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____ All Health Care information (Personal Health Information)

_____ Other: _____

This information is to be disclosed to Harkness Medical Group.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, I herby release the facility, its employees, and providers from any legal responsibility or liability for disclosure of all healthcare information relating to such diagnosis, testing, or treatment.

_____

Patient/Representative Signature: _____

Printed Name: _____

Date: _____