Puget Sound Family Health and apothecary

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Patient Information

First Name _____ Last Name _____ Date _____

Sex M / F / N/B Date of Birth _____ Email _____

May we leave detailed information on your email? Yes / No

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

May we leave detailed information on your phone? Yes / No

Occupation/Employer _____ Referred by _____

Emergency Contact _____ Phone _____ Relationship _____

Name of Parent/Guardian (minors) _____

Insurance Information

We will obtain a copy of your insurance card and ID before your initial visit. Please be advised that failure to provide us with your insurance information will result in patient responsibility of all charges accrued during visit.

Primary Insurance _____ Insurance Phone _____

Ins. ID # _____ Group/Policy # _____

Subscriber's Name _____ DOB _____

Assignment and Release

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Rife and all other a ssociate providers at Puget Sound Family Health all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

☐ **By checking this box, I acknowledge that I am signing electronically.**

For office use only: Wellevate created on: _____

HIPAA Information and Consent Form

The Health Insurance and Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. *www.hhs.gov*

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with laboratories, health insurance payers as is necessary and appropriate for your care. We may be able to view health care records from other providers and other healthcare providers may have access to your records in the shared records features of our EHR. You may request that record sharing is disabled. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. Our contracted third party is HIPAA compliant and may do this by telephone, e-mail, text message or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of labs in the conduct of business. These labs may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.
9. You have the right to request restrictions on the use of your protected health information and to request a change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

☐ **By checking this box, I acknowledge that I am signing electronically.**

Payment for Provider Services

Payment for physician services, acupuncture, massage, herbal and nutritional supplements, diagnostic tests and all other items must be made at the time of service unless other arrangements have been made with the office manager or doctor. Puget Sound Family Health accepts cash, credit cards, personal checks and many insurance policies. A $25.00 processing fee will be charged for all returned checks. Outstanding balances beyond 30 days will be charged a monthly interest fee of 1.5%. Balances are automatically sent to TSI Profit Recovery and Collection Services after 90 days.

If pressing financial hardship should interfere with your ability to pay for services, please discuss this with our office manager before your initial visit. Every effort will be made to arrange a flexible payment schedule to meet your needs. This communication must take within 30 days of an accrued charge.

Washington law requires that insurance companies, with the exception of HMOs and self-insured groups, cover naturopathic medical care. Puget Sound Family Health contracts with a professional billing company to process insurance claims. Health insurance is configured between you and your insurance company. **We are not responsible for any coverage not provided by your insurance and are unable to make any guarantees about your coverage. Please contact your insurance prior to your visit to best understand your coverage.**

Cancellation & No-Show Policy

All **cancellations/reschedules require a 24-hour notice**. **"No-showing" for your appointment is defined by being over fifteen minutes late for your appointment. Canceling within the 24 hour period, "no-showing" for your appointment, and beginning your telemedicine visit while driving will all result in a charge up to the cost of your scheduled visit (up to $350). This is not billable to insurance.** Failure to contact your insurance and guarantee coverage before the 24 window of your visit resulting in a late cancellation is not an exception. Our physicians block a substantial amount of time for each appointment and they, as well as other awaiting patients, would like the opportunity to fill these spots. We do not double book appointments and are unable to fill these appointments last minute.

I, _____, understand that I am ultimately responsible for the balance of my account, for any and all professional services rendered on my behalf, as well as late fees or service charges. I understand that giving Puget Sound Family Health my insurance information does not guarantee insurance approval or payment and I accept full responsibility for the payment of services in full amount due; even if my medical insurance provider does not pay.

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

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Administrative Services Fee

It is an honor and privilege to provide quality healthcare to you and your family. The staff and providers at Puget Sound Family Health are committed to your health and wellness. We strive daily to provide personal care that reflects this commitment. However, this often means providing care that is not covered by insurance. Every year, more time and responsibility are required of primary care offices to handle administrative steps for tasks that are completed outside of providing in-person medical care. These tasks include completing pre-authorizations, coordinating lab orders and results, referrals, and prescriptions, answering billing questions, medical records requests, and generating letters of medical necessity. None of these tasks are billable to insurance. This is exacerbated yearly by changes in the health insurance industry that results in services that were at one time covered to now either being partially covered, or not covered at all. While inflation is driving the cost of operating a practice higher, health insurance is driving the reimbursement rates for providers lower.

In order to continue to provide this exceptional care, our Administrative Services Fee has increased to $20. **Effective MARCH 1, 2022, a $20 fee will be charged per visit to each patient.** We are aware that healthcare is expensive. By capping our additional fees at $20 per visit for each patient, we are not charging you for services that may not be covered by your insurance, and which could end up costing you more. For example, these fees could include a facility fee, venipuncture, medical records charges, phone consults for labs and prescriptions, prolonged visit fees, health education fees, or processing fees that can exceed $100.

This new fee will be charged to all patients in our practice. You will be asked to sign a new Administrative Service Fee Consent Form before your next visit. Agreeing to this policy is required to be seen at this clinic. In summary, it covers the cost of enhanced services not covered by your health insurance or visit fee. Please note, it does not cover the cost of any healthcare services covered by your health insurance; nor does it cover the cost of any healthcare services if you have no insurance coverage. If it is demonstrated that your particular healthcare coverage includes separate payments for these Administrative Services, we will make an adjustment to the fee, if needed. This Administrative Services Fee does not impact your co-pay.

Our decisions are always based on putting the patients first. We take pride in the quality of care that we provide to our community and want to be able to continue doing so in the face of never-ending reductions in reimbursements and increases in the cost of operation. As always, thank you for the honor of caring for your family and children. We are available to answer any questions that you may have regarding this fee.

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

**You must sign this document in order to complete a visit at PSFH. Failure to do so will result in an automatic cancellation and subsequent fees.*

☐ **By checking this box, I acknowledge that I am signing electronically.**

TELEMEDICINE CONSENT

I, _____, understand that telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that the information disclosed by me during the course of my treatment is confidential. By signing this consent, I agree to proceed with a telemedicine visit and certify I am a resident in the state of Washington.

I understand that not all services may be completed over telemedicine and if my provider believes another form of medical service (e.g. in-person) would better serve me, I will oblige to scheduling an in-person office visit with my provider or another medical service referred to by my provider.

I understand that a telemedicine visit does not replace an in-person visit and, therefore, I am proceeding at my own risk and understanding. I understand that if my condition should worsen I will contact 911.

I certify that the information provided to my provider is true and accurate to the best of my ability and I am disclosing all pre-existing conditions. I understand that omitting medical information or misinforming my provider may result in inaccurate diagnosis and treatment.

Failure to comply with the following may result in a voluntary no-show and subsequent charges:

- Attending the telemedicine while driving
- Attending the telemedicine visit with no visual or audio
- Failure to submit the Intake paperwork prior to the visit start time

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

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OFFICE POLICIES AND PROCEDURES

Office Visit Fees

Office visit fees are determined by a combination of the level of complexity, procedures performed, and time spent. Because of this, we are unable to predict the exact cost of an office visit. Please contact the office to discuss an estimated cost for your visit. Visit costs are non-negotiable.

Non-Covered Services

During a visit at PSFH, your provider may perform a service or recommend a test, procedure, or prescription that is not covered by insurance. It may also happen that your insurance company requires a pre-authorization, a letter of medical necessity, or a prescription to cover certain services or products. While our providers can accommodate these requests from your insurance company, we can not guarantee coverage. Please call your insurance prior to your first visit to confirm your personal benefits.

Self-pay and Self-pay with sliding scale discounts

Payment is expected at the time of service to receive a discount. For patients seen in the office, we will collect at the time of service. For patients receiving care through Telemed (phone, doxy.me) we ask that you check your account balance on the patient portal and promptly make a payment. The self-pay discount is 20% off of our regular fees. If you are military or have medicare/Medicaid you will receive an additional 10% discount as well as a 10% discount on supplements. These prices are subject to change and are non negotiable.

Prescription Refill or Renewal

Please don't wait until the last minute to request a refill for your prescription! When you are getting low contact your pharmacy and ask them to fax us a refill request. Due to a high volume of these requests we are unable to guarantee we can respond to these on the same day. Please allow 5 business days to respond. Please keep in mind, if you are out of refills or it has been over six months since you have seen your provider, your provider may request an appointment with you to ensure they are providing the best care to you. Compliance to instructions from your provider is critical which includes completing labs and a visit to discuss continuation of medications. We receive a high volume of immediate refill requests that disregard the proper protocol. Effective March 1, 2022 these requests will result in a $25 fee, not billable to insurance. We will do our best to work with you on an emergency basis. Please note that the fee will be charged when we are able to accommodate these requests, but does not guarantee that these requests will be accommodated.

Questions for your Provider

We do our best to relay information to your providers at your request, however, it is difficult for providers to best care for you outside of your appointments in a lot of cases. Please utilize the PatientPortal to communicate with your provider. Your provider may decide that your question deserves more time and follow-up questions and may request to schedule an appointment with you.

Lab Orders and Results

We encourage patients to be informed on preferred labs for their insurance plans. For your convenience, we have a phlebotomist in-office on Tuesday mornings. Lab results are only shared after they've been discussed during a visit. This helps ensure that all of your questions are answered and that the doctor has the appropriate time to explain the results and discuss what treatments are medically necessary.

Medical Records Requests

If you are requesting medical records we ask that you fill out the medical records request form. Please allow us 30 days to process the request after we receive the records request form.

Testosterone Replacement Patients

Please review your signed testosterone waiver for instructions and guidelines. To remain in the program you are required to follow the instructions to schedule labs and a follow-up visit before your prescription runs out. A lapse in testosterone injections does not have life-threatening medical consequences and your failure to comply with the instructions and guidelines will most likely result in a delay in treatment.

Lab Requisition Form

Please call your lab before you arrive to ask them if they have received your lab order and if you need to schedule. Labs do not guarantee that they will receive and process lab orders the same day so please request a requisition form before leaving your appointment if you are planning on going the same day.

I _____, understand that by becoming a patient of Puget Sound Family Health means that I am consenting to abide by the aforementioned policies and procedures and failure to oblige may result in a delay in care, accruing charges, and dismissal from the practice.

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

☐ **By checking this box, I acknowledge that I am signing electronically.**

CONSENT FOR TREATMENT

I understand that clinicians may perform general diagnostic procedures and physical examinations, psychological counseling, lifestyle counseling, exercise prescriptions, acupuncture, ayurvedic services, topical treatments, herbal medicine, natural medicine, dietary advice and therapeutic nutritional counseling, soft tissue and osseous manipulation, electromagnetic and thermal therapies, venipuncture, PAP smears, and minor office procedures such as ear clearing and wound dressing.

I understand that Washington State law does not authorize naturopaths to treat me for any cancer or malignancy and that I am required to be under the care of a medical doctor or osteopathic physician (oncologist) while receiving care at Puget Sound Family Health.

I _____, hereby authorize the providers listed above to perform the aforementioned procedures as necessary to facilitate my diagnosis and treatment. Furthermore, I agree that I have read and agree to all forms included in this document. Failure to sign all forms may result in an automatic cancellation of your appointment.

Patient/Guardian Printed Name _____

Patient/Guardian Signature _____ Date _____

☐ **By checking this box, I acknowledge that I am signing electronically.**

Patient Name _____ Date _____

Age _____ Date of Birth _____ Date of Last Physical Examination _____

Reason for Visit: _____

Symptom History: Indicate which symptoms you are currently experiencing and which you have experienced in the past year. Choose no option if neither apply.

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Muscle / Joint / Bone Pain / Weak / Numb in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

Genito-Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful urination

Gastrointestinal

- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Cardiovascular

- Chest pain
- Low blood pressure
- High blood pressure
- Irregular heartbeat
- Poor circulation
- Rapid heartbeat
- Swelling of ankles
- Varicose veins

Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay Fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-flashes
- Vision-halos

Skin

- Bruises easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sores that won't heal

Men Only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

Women Only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Vaginal discharge
- Painful intercourse

Date of last menstrual period: _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Conditions: Place a check mark next to any conditions you have or have had in the past.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart disease
- Hepatitis
- Hernia
- Herpes
- High cholesterol
- HIV Positive
- Kidney disease
- Liver disease
- Measles
- Migraines
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostrate problem
- Psychiatric care
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid fever
- Ulcers
- Vaginal infections
- Venereal disease

Medications - List medications you are currently taking:

Drug Allergies

Pharmacy _____

Phone _____

Health History: *Fill in health information about your family:*

Relationship	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Siblings				

Hospitalizations / Injuries:

Year	Hospital	Reason and Outcome

Pregnancies:

Year of Birth	Gender	Complications (if any)

Health Habits:

Caffeine	◯	
Alcohol	◯	
Tobacco	◯	
Cannabis	◯	
Drugs	◯	
Other	◯	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

☐ ✔ **By checking this box, I acknowledge that I am signing electronically.**