**OLY MED FAMILY WELLNESS CENTER PLLC**

 **ACCOUNT REGISTRATION FORM**

PATIENT INFORMATION\_\_\_\_

Marital Status

SINGLE 

MARRIED 

DOM. PART.

DIVORCED 

LEG. SEP 

WIDOWED 

Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE INITIAL LAST

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_

Gender : Female \_\_\_\_\_ Male \_\_\_\_\_ Trans \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_Choose Not to Disclose \_\_\_\_

S.S. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St \_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we call you at work? Yes \_\_\_\_ No \_\_\_\_

**May we leave a message with your lab/test results on your voicemail? Yes \_\_\_\_ No \_\_\_\_**

Email Address **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** @ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we leave a message with your lab/test results on your email? Yes \_\_\_\_ No** \_\_\_\_

SPOUSE, PARENT OR GUARDIAN INFORMATION *Living in the same household as the patient* \_\_

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE LAST

Relationship to Patient Parent \_\_\_\_ Guardian \_\_\_\_ Spouse \_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Day Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT NOT LIVING IN PATIENT HOUSEHOLD *Required if child is covered under this parent’s Insurance*

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE LAST

Home Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Day Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY NUMBER *Nearest Relative/Friend outside of your household \_*

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eve. Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eve. Phone (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE: YES NO A LIVING WILL

 YES NO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

 YES NO ADVANCE DIRECTIVE

 YES NO DO YOU WISH ADDITIONAL INFORMATION

THE EXISTANCE OR EXECUTION OF A LIVING WILL, DURABLE POWER OF ATTORNEY FOR HEALTH CARE, OR WRITTEN ADVANCE DIRECTIVE IS NOT A CONDITION OF RECEIVING HEALTH CARE SERVICES AND MAY NOT OTHERWISE BE USED TO DISCRIMNATE AGAINST AN INDIVIDUAL.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OLY MED FAMILY WELLNESS CENTER PLLC**

INSURANCE INFORMATION

\*\*It is patient responsibility to contact each insurance company when there is double coverage\*\*

**Primary Ins. is Through: \_\_\_\_**Your Employer \_\_\_\_Spouse Employer **\_\_\_\_**Domestic Partner **\_\_\_\_**Parent’s Employer \_\_\_\_Other Relationship to insurance policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(i.e. Self, spouse, parent, or partner)

Insurance policy holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. policy holders’ birth date\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_

**Ins. ID# \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Prefix letters Date insurance plan began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Ins. is Through: \_\_\_\_**Your Employer \_\_\_\_Spouse Employer **\_\_\_\_**Domestic Partner **\_\_\_\_**Parent’s Employer \_\_\_\_Other Relationship to insurance policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(i.e. Self, spouse, parent, or partner)

Insurance policy holder’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. policy holders’ birth date\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_ ID

**Ins. ID#\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ins. Group# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Prefix letters Date insurance plan began:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AUTHORIZATION/RESPONSIBILITY FOR THE TREATMENT OF A MINOR:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the parent or legal guardian of my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize and consent to emergency and routine medical treatment and procedures to be performed for my child by licensed medical personnel when deemed necessary or advisable and I cannot be contacted. Regarding financial responsibility for this child, he/she will remain on my account and I will be responsible for his/her medical bills regardless of changes in family situations, (i.e. divorce, custody issues, etc.) until he/she is 18 years of age. I also authorize the release of the minors PHI for payment purposes. Authorization and financial responsibility shall continue and be in full force and effect until revoked in writing by me.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, & FINANCIAL RESPONSIBILITY:**

I authorize Oly Med Family Wellness Center or my insurance company to release any PHI information required for processing any insurance claim(s). I also authorize my insurance benefits to be paid directly to the doctor. I understand that direct billing of insurance companies is done as a courtesy by Oly Med Family Wellness Center and that I am financially responsible for the full amount of the charges which are not covered by insurance benefits. I also understand that Oly Med Family Wellness Center will submit claims to my insurance company using the information that I have provided for this purpose, and I agree that I will be responsible for the charges if the insurance company indicates that coverage was not in effect or that I was assigned to a Primary Care Physician (PCP) elsewhere. If being signed by a spouse or partner, I understand that these provisions apply to the patient name above.

**Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Document Revision: 12/2014

**OLY MED FAMILY WELLNESS CENTER PLLC**

NOTICE OF PRIVACY PRACTICES

**ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting Oly Med Family Wellness Center.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Policies.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient or legally authorized individual signature Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed name *if signed on behalf of patient*  Relationship

This form will be retained in your medical record.

**FAMILY RELEASE FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Oly Med Family Wellness Center to disclose the following health care information:

**If you wish to authorize someone access to your healthcare information, please choose from the following options:**

1. 🞏 **All :** all health care information in my medical record **INCLUDING** information relating

to mental health, sexually transmitted diseases (including HIV and AIDS), and alcohol/drug

dependence.

1. 🞏 **Limited:** all health care information in my medical records **EXCLUDING** the following

 information **(check all that apply):**

🞏 Mental health

🞏 Sexually transmitted diseases (including HIV and AIDS)

🞏 Alcohol/drug dependence treatment

🞏 Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information may be shared with the following individuals:

NameRelationship

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I **do not** wish to authorize any individual to access my health care information

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Printed Name

This authorization is valid until Oly Med Family Wellness Center receives written revocation from the patient.

**This form will be retained in your medical record. Updated: 12/2016**

**OLY MED FAMILY WELLNESS CENTER PLLC**

**PATIENT RESPONSIBILITY REGARDING MISSED OR CANCELLED
APPOINTMENT**

**I understand and agree to the following:**

1. **It is my responsibility to notify Oly Med Family Wellness Center (360-753-0396)**

 **24 hours prior to my scheduled appointment if I am unable to keep it.**

1. **I will be billed a $50 No-Show Fee or Cancellation Fee in the event that I miss an appointment or fail to cancel 24 hours prior to my scheduled appointment.**
2. **A missed appointment could result in my discharge from the clinic.**
3. **All patients taking medications will need to be seen a minimum of twice yearly.**

**PATIENT RESPONSIBILITY REGARDING CO-PAYS, DEDUCTIBLES AND ACCOUNT BALANCES**

**I understand and agree to the following:**

1. **I am responsible for my co-pay, payment towards an upfront deductible, estimated out of pocket amounts (based on visit type and my insurance plan), prior balances, and non-covered services at the time of service.**
2. **I will be billed the balance owed after my claim is processed by my insurance company.**
3. **I will be responsible for the $10 fee that covers the cost of multiple statements after the second invoice deadline.**
4. **My balance will be referred to a collections agency if it is not paid by the final due date listed on my bill or if I default payment on a clinic-approved pay plan. Referral to a collections agency may result in my discharge from the clinic.**

**Notice: For your protection against fraud and identity theft, it is our office policy to take your photo at your initial appointment. This policy is HIPAA protected.**

**PATIENT RESPONSIBILITY REGARDING TELEPHONE SERVICE**

**I understand and agree to the following:**

**Certain phone calls in place of an office visit will be charged a fee and I will be personally responsible if insurance does not pay for the telephone consultation. (Example: calls requesting advice and prescriptions when traveling; prolonged discussions by guardian for care of patient).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OMFWC Witness Date**

**Document Revision: 10/2018 \*Fees are subject to change**

**OLY MED FAMILY WELLNESS CENTER PLLC**

**24 Hour Appointment Cancellation Policy**

Oly Med Family Wellness Center, PLLC has a 24 hour cancellation/rescheduling policy. If an appointment is missed, canceled or changed with less than 24 hours notice, there will be a $50 charge.

Please call us at 360-753-0396 by 2:00 p.m. the day prior to your Tuesday – Wednesday scheduled appointment. To cancel a Monday appointment, please call our office prior to 12:00 p.m. on Thursday.

The clinic realizes that there are many things that come up in people’s day to day lives.

While truly sympathetic, the clinic cannot absorb the financial responsibility of last minute cancellations. Exceptions are rare, however they may be considered on a case to case basis.

By signing below, you acknowledge that you have read and understand the cancellation policy for Oly Med Family Wellness Center, PLLC.

Thank you for your understanding and cooperation.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**