Western Washington Medical Group
Marysville Family Medicine

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, _____, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

_____ _____
Signature of client (or personal representative) Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:
Personal Representative's Name: _____

Relationship to Client: _____

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify)

_____
_____

_____ _____
Employee Name Date

This form will be retained in your medical record

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Patient No-Show and Cancellation Policy

We strive to provide excellent medical care to our patients. In order to be consistent with this, we have a Patient No-Show and Cancellation Policy that we have adopted for our clinic. When an appointment is scheduled, that time has been reserved for you and when it is missed or cancelled on short notice, that time cannot be used to see another patient.

Our policy is as follows: You may cancel your appointment up until **24 hours before** your scheduled appointment with no consequences. We will be happy to reschedule the appointment for you and leave the open time for another patient. If you miss your appointment or cancel any time the day of your appointment, Western Washington Medical Group, Department of Family Medicine reserves the right to bill you **$50.00** for each no-show or late cancellation. This fee is the patient's responsibility and is not billable to insurance.

Additionally, if a patient is more than 10 minutes late to his/her appointment without prior notification, we reserve the right to cancel the appointment and the cancellation fee of **$50.00** will apply.

We do realize that on rare occasions emergencies or circumstances may arise beyond your control. We will address these situations with you should that occur.

If you have any questions regarding this policy, please direct them to the practice administrator. We thank you for working with us to ensure that we are able to provide the best service possible to all of our patients.

I have read and understand the Patient No-Show and Cancellation Policy of the practice and I agree to the terms. I also understand that such terms may be amended periodically by the practice.

Patient's Signature: _____ Date: _____

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FINANCIAL AGREEMENT

We consider all patients as **"private pay"** unless their insurance is one with whom we have a contractual agreement. We will bill your insurance as a courtesy, but the balance for "**private pay**" patients is due and payable within 30 days. Many insurance plans only cover a certain percentage of the fees charged. Many insurance companies only cover the "usual and customary" fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care; therefore, it is the patient's responsibility to check their benefits **prior** to being seen.

Please be familiar with the benefits provided by your health plan

If your insurance requires a referral or if we need insurance authorization prior to your visit, it is **YOUR** responsibility to see that your health plan requirements are met. If you're insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at time of service, if you are unable to pay your co-pay at time of service there may be an **additional $15.00 fee** charged to your account.

Should the account be referred over to our collection agency the undersigned, or their agent, will be responsible for payments of interest on the unpaid balance of 1% per month from the date of the service, collection fees, reasonable attorney fees and court costs.

We charge **$35.00** for any NSF checks. (Per RCW 62A-3-515 & 520)

With my signature, I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.
I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Patient's Signature_____Date_____

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FRIENDS AND FAMILY RELEASE

Patient's name PRINTED	Patient's ACCOUNT NUMBER	Today's date

I give the physicians and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition with person listed below.
The consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information current, as I recognize that relationships and friendships change over time.

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:
(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic.)
[ ] HIV (Aids virus) **[ ]** Sexually Transmitted Diseases (STD's)
[ ] Psychiatric disorders/Mental health **[ ]** Alcohol/Substance abuse
[ ] All other Health Information
Other: _____

<u>Patient's Personal Phone Information: NOTE - This is DIFFERENT than the above info.</u>

Please provide us with **YOUR *best, most current*** phone contact information. This information will become part of your permanent medical record *unless/<u>until you change it</u>*. You can change this information simply by asking to complete a new form.

Please note: by approving the option to leave a detailed message you are allowing us to leave sensitive health information and specifics related to referrals.

First phone number: _____ Cell Work Home OK to leave detailed message: Y N

Second phone number: _____ Cell Work Home OK to leave detailed message: Y N

Third phone number: _____ Cell Work Home OK to leave detailed message: Y N

X _____ _____
PATIENT OR GUARDIAN SIGNATURE RELATIONSHIP TO PATIENT

X _____
PRINTED name of person signing