Welcome to Western Washington Arthritis Clinic

We look forward to meeting you and assisting with your medical care.

In order to provide comprehensive, coordinated, and efficient care, some preparation is required prior to your first clinic visit. Please review the contents of this "new patient packet" carefully and bring it with you on the day of your appointment.

INFORMATION FOR THE DAY OF YOUR APPOINTMENT

• Please arrive 20 minutes before your scheduled appointment time in order to complete the registration process (allow longer if you could not complete the pre-visit forms on line in advance).

• Items to bring with you:

o New patient packet –All forms *must* be completed *before* your appointment time in order to be seen by the physician

o Picture ID (i.e. Driver's License)

o Insurance Card and co-pay.

o Any copies of your records not already supplied that you feel may assist us in your care.

INSURANCE AND BILLING INFORMATION

We accept most forms of insurance and will bill your insurance company directly on your behalf. We do suggest you contact your insurance company as soon as possible to verify your coverage and to find out if your plan requires an authorization from your primary care provide.

Thank you for your preparation and attention to these important details. We look forward to seeing you in the near future. Please feel free to bring a family member or friend to your visit. It can also be helpful to share a written list of your questions or concerns with us at the beginning of your visit to assist us in addressing your needs and priorities. If you have any questions before your appointment or about the packet, feel free to call us at 425-248-2626

We received a referral from your Physician for your appointment here at Western Washington Arthritis Clinic

Our *first* goal is to help patients receive a diagnosis, or to confirm the diagnosis that best fits their medical issues and to treat complex autoimmune diseases. This means we will generally act *as consultants only* for some patients. Many diagnoses such as Fibromyalgia or Hypermobility, or other disease states do not require ongoing rheumatologic care and will be referred back to your PCP or referring physician with our recommendations for treatment.

We will not be providing prescription pain management services, as this is better managed by specialists in that area

To accomplish these goals, if you choose to be seen at Western Washington Arthritis Clinic you will receive one new consultation visit and one follow up visit if any tests are performed. We will then provide written recommendations for your referring physician if that is where we feel treatment would best be rendered. If your diagnosis is one that is best treated by <u>us</u> we will set up further appointments.

While we endeavor to see patients in a timely manner, certain circumstances could arise where appointments may need to be rescheduled due to Physician schedule changes.

If you have concerns about any of the above mentioned issues please call if you wish to cancel your appointment.

Please fill out the following pages *completely* before your appointment to help us determine your care plan.

COMMUNICATION AND PRESCRIPTION REFILL POLICY

The physicians of Western Washington Arthritis Clinic each see patients four days a week, 10 hours a day, as do their Medical Assistants.

When they are not in the office, each assistant has a voice mailbox to take non-emergent incoming calls from patients and pharmacies. It is important for you to allow time for your prescriptions to be filled before running out. Our policy is to allow 48 business hours for common prescription refills. Please remember that some insurance companies require pre-authorization for various medications, and that may extend the time required to fill them.

There will be no pharmacy phone calls answered for medication refills after hours, on weekends, or holidays when the office is closed. The Answering Service will NOT pass on refill messages to the on-call physician.

If you are on a Schedule 2 medication that requires you to hand carry the prescription to the pharmacy, please look it over ***before*** you leave the office, as they can only be re-written during business hours. ***It is very important that you remember there are 48 business hours needed for refills and to plan accordingly***.

Understanding Your Costs and Coverage

Thank you for choosing Western Washington Arthritis Clinic. We know that understanding your healthcare costs can be a challenge — we are here to help. Your healthcare costs depend on many factors such as your insurance plan and its cost-sharing features, where you are cared for and the type of services you receive. There are ways to prepare for your financial responsibilities before, during and after your medical care. From knowing your insurance coverage ahead of time to reading your explanation of benefits to understanding your bill, we want to help you know how best to manage your financial responsibilities.

Insurance Coverage

Insurance coverage varies among individual insurers and policies. Most insurers publish benefit information online or in a benefit manual that you can obtain directly from your insurer. We encourage you to call your insurance company before your visit to understand what your insurance will pay, which providers are in network, and your out-of-pocket responsibility. You may need lab, x-ray or other testing as part of your evaluation. Please check with your insurance to see if there are any restrictions regarding authorizations or referrals needed for these services

Western Washington Arthritis Clinic staff will ask for your insurance information before your visit. After your visit, we will file claims for services rendered to your insurance plan(s). If you have coverage with more than one insurance company, it may be necessary for you to help coordinate billing and payment information between payers.

After your insurance has processed the claim, you should receive an Explanation of Benefits (EOB) from your insurer. This statement explains what services were billed, what was covered by the insurer (including a reason if a service was not covered) and any balance you will owe. You will receive a statement either in the mail (or electronically if you have selected to receive your statements in this manner) from us. This statement will show the balance you owe after your insurance has processed your claim.

FINANCIAL AGREEMENT

We consider all patients as “private” unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for “private” patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers 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, 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 your 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 the time of service, if you are unable to pay your co-pay at the time of service there will be an additional $15.00 fee charged to your account. Only one non-payment of co-pays will be allowed.

No show, late cancellation fees, and co-pays must be paid prior to scheduling your next office visit.

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 service, as well as collection fees, reasonable attorney fees and court costs.

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

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 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.

Printed Name _____ Date of Birth _____

Signature _____ Today’s Date _____

No Show Fee Policy for New and Established Patients

Our goal is to provide quality care in a timely manner. We schedule appointments in order to provide each patient with the individual attention they deserve.

Cancellation of an Appointment:

We urge you to keep your scheduled appointments whenever possible. In the event you need to cancel, please contact the clinic by phone at 425-248-2626. Your early cancellation allows us to offer your appointment time to another patient needing medical care. In order not to be charged for the visit, established patient visits need to cancel 24 hours prior to their appointment or there will be a $75 charge. New patient visits must be cancelled 48 hours in advance of their appointment or a $150 charge will occur

No Show Policy:

A "no show" is someone who misses an appointment without CANCELLING it in advance. We will charge a $150 fee to new patients who do not arrive for their scheduled appointment or late cancel and $75 for established follow-up patients. Voice messages to our main line are time stamped and may suffice.

No Show Fee Policy Acknowledgement:

By accepting a new patient appointment, or an established patient follow-up appointment you are agreeing to this cancellation/"no-show" policy.

If you do not agree, please cancel your appointment immediately. If you do not cancel, you will be billed as outlined above. Late cancellation and "no show" charges must be paid before any further appointments will be made

Office Visit Questionnaire

1. Please check (✓) the ONE best answer for your abilities at this time:

At this moment, are you able to:	W/out Any Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train or airplane?	0	1	2	3
i. Walk two miles?	0	1	2	3
j. Participate in sports and games as you would like?	0	1	2	3

2. Since your last visit, have you started or stopped a medication or therapy, seen other providers, been hospitalized, had operations, had an accident, missed work or changed jobs, had other stresses, or had family members with new illness? Yes ___ No ___ (If you answered YES, please give details on back of this sheet.)

3 Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

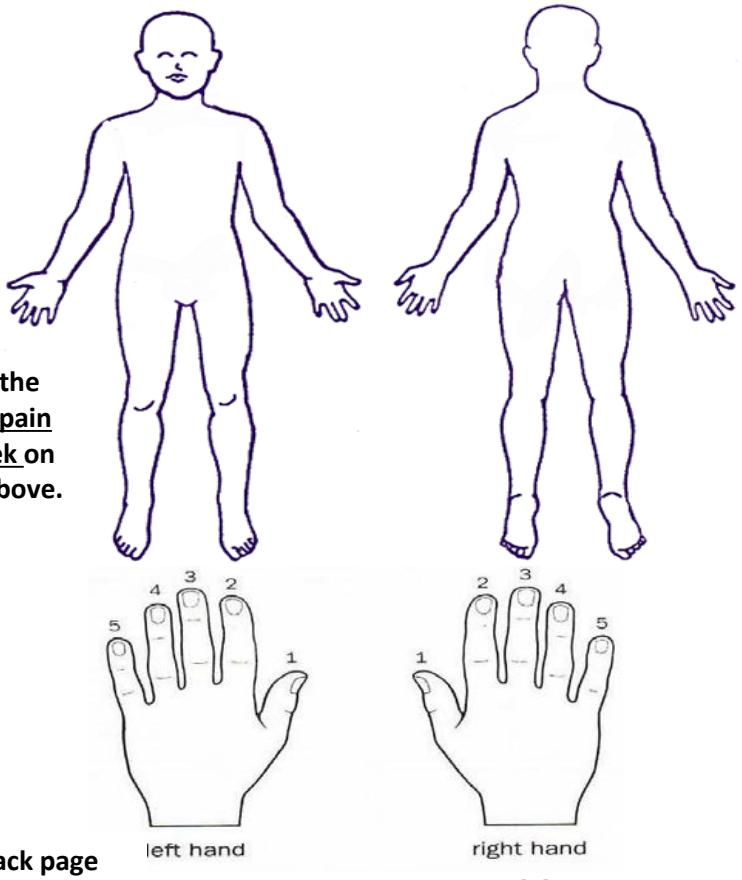
VERY WELL ○ 0 ○ 0.5 ○ 1 ○ 1.5 ○ 2 ○ 2.5 ○ 3 ○ 3.5 ○ 4 ○ 4.5 ○ 5 ○ 5.5 ○ 6 ○ 6.5 ○ 7 ○ 7.5 ○ 8 ○ 8.5 ○ 9 ○ 9.5 ○ 10 **NOT WELL AT ALL**

4 How much pain have you had because of your condition over the past week?

Please indicate how severe your pain has been:

NO PAIN ○ 0 ○ 0.5 ○ 1 ○ 1.5 ○ 2 ○ 2.5 ○ 3 ○ 3.5 ○ 4 ○ 4.5 ○ 5 ○ 5.5 ○ 6 ○ 6.5 ○ 7 ○ 7.5 ○ 8 ○ 8.5 ○ 9 ○ 9.5 ○ 10 **PAIN AS BAD as it could be**

Please shade all the locations of your pain over the past week on the body figures above.



FN 0-10		PN 0-10
1=0.3	16=5.3	
2=0.7	17=5.7	PTGL 0-10
3=1.0	18=6.0	
4=1.3	19=6.3	
5=1.7	20=6.7	RAPID3 0-30
6=2.0	21=7.0	
7=2.3	22=7.3	
8=2.7	23=7.7	
9=3.0	24=8.0	
10=3.3	25=8.3	
11=3.7	26=8.7	
12=4.0	27=9.0	
13=4.3	28=9.3	
14=4.7	29=9.7	
15=5.0	30=10	

Please complete back page

5. Please check (✓) if you have experienced any of the following over the last month:

___ Stiffness in AM for _____ minutes
___ Swelling in any joint (specify) _____
___ Muscle weakness
___ Muscle pain, aches, cramps
___ Unusual/new fatigue
___ Depression
___ Anxiety
___ Problems falling asleep
___ Problems staying asleep
___ Weight gain (>10 lbs)
___ Weight loss (<10 lbs)
___ Fever or night sweats
___ Swollen glands
___ Loss of appetite
___ Skin rash or hives
___ Unusual bruising or bleeding
___ Other skin problems

___ Loss of hair
___ Dry eyes __ Dry mouth
___ Other eye problems
___ Problems with hearing
___ Ringing in the ears
___ Stuffy nose
___ Sores in the mouth
___ Memory or thinking prol
___ Headaches
___ Dizziness
___ Numbness or tingling of
___ Falls
___ Balance problems
___ Fainting spells
___ Shortness of breath
___ Cough
___ Wheezing

___ Irregular breathing while sleeping
___ Pain in chest
___ Heart pounding (palpitations)
___ Trouble swallowing
___ Heartburn or stomach gas
___ Stomach pain or cramps
___ Nausea
___ Vomiting
___ Constipation
___ Diarrhea
___ Dark or bloody stools
___ Problems with urination
___ Gynecological (female) problems
___ Women: Menses not regular (new issue)
___ Smoking cigarettes, pipe or cigars
___ More than 2 alcoholic drinks daily

6. List any refills you need; specify ___ 30 days or ____ 90 days (check one)

7. Please list any questions you hope to discuss today.

FOR OFFICE USE ONLY:

9/20/2017

WESTERN WASHINGTON MEDICAL GROUP ***REGISTRATION FORM***

ACCOUNT#_____ **NEW** _____ **UPDATE** _____

PATIENT LAST NAME	**FIRST NAME (legal)**	**MI**	**PREFERRED OR NICKNAME**	**DATE OF BIRTH**

RACE	**ETHNICITY**	**PREFERRED LANGUAGE**	**SOCIAL SECURITY #**

SEX M ___ F ___ Other: _____ (Please List)	**GENDER IDENTITY:** __Genderqueer identifies as neither Male or Female __Identifies as Male __Female-to-male __Additional gender category or other, please specify _____ __Identifies as Female __Male-to-female __Choose not to disclose	**SEXUAL ORIENTATION** __ Choose not to disclose __ Heterosexual (straight) __ Bisexual __ Homosexual (gay/lesbian) __ Other _____

MAILING ADDRESS	**APT #**	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**
STREET ADDRESS	**APT #**	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**

HOME PHONE	**WORK PHONE** **EXT**	**CELL PHONE**	**PREFERRED EMAIL ADDRESS**
( )	( )	( )	

REFERRING DOCTOR	**HOW DID YOU HEAR OF US?**	**MARITAL STATUS**
	Internet ___ Google Maps ___	MARRIED _____ DIVORCED _____ OTHER _____
PRIMARY CARE DOCTOR	Friend/Family ___ Drove by location ___ Insurance Company ___ Mailer/ Marketing ___	SINGLE _____ WIDOWED _____ SEPARATED _____

PHARMACY NAME, PHONE NUMBER AND LOCATION

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU: RETIRED_____ OR DISABLED_____?)

EMPLOYER NAME	**OCCUPATION**

STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**

PRIMARY INSURANCE

INSURANCE COMPANY NAME	**RELATION TO SUBSCRIBER**	**COPAY**
SUBSCRIBER'S NAME	**SUBSCRIBERS EMPLOYER**	

SUBSCRIBERS DATE OF BIRTH	**SUBSCRIBER'S SEX**	**SUBSCRIBERS ID #**	**GROUP NUMBER**
	MALE ___ FEMALE ___ OTHER ____		

SECONDARY INSURANCE

INSURANCE COMPANY NAME	**RELATION TO SUBSCRIBER**	**COPAY**
SUBSCRIBER'S NAME	**SUBSCRIBERS EMPLOYER**	

SUBSCRIBER'S DATE OF BIRTH	**SUBSCRIBERS SEX**	**SUBSCRIBERS ID #**	**GROUP NUMBER**
	MALE ___ FEMALE ___ OTHER ____		

EMERGENCY CONTACT

(NOT LIVING WITH YOU)	**NAME**	**RELATIONSHIP**	**PHONE NUMBER- HOME/WORK/CELL** ( )

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ **SELF** (* If self do not fill in right field.) _____ **SPOUSE** _____ **PARENT** _____ **GUARDIAN**	**SOCIAL SECURITY #**	**LAST NAME**	**FIRST NAME**	**MI**
	STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE** **4 DIGIT**
	HOME PHONE ( )	**WORK OR CELL PHONE** **EXT** ( )	**DATE OF BIRTH**	**SEX** M __ F __ Other __

WORKERS COMP CLAIM #	**DATE OF INJURY**	**EMPLOYER**	**STATE OR SELF INSURED?**

I, the patient or guardian, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize **Western Washington Medical Group** to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

PATIENT SIGNATURE ***DATE***

For office use only

Dr._____ **Ins. code**_____ **Acct #**_____ **Initials**