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

PRIMARY CARE DOCTOR

HOW DID YOU HEAR OF US?
Internet ☐ Google Maps ☐
Friend/Family ☐
Drove by location ☐
Insurance Company ☐
Mailer/ Marketing ☐

MARITAL STATUS
MARRIED ☐ DIVORCED ☐ OTHER ☐
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 by voicemail, text, email or portal, which may contain details of my medical condition.
By voluntarily providing your mobile phone number to WWMG, you agree to receive recurring non-marketing SMS messages regarding appointment reminders, cancellation or rescheduling, patient onboarding, care-related notifications, and billing updates. Message frequency varies. Message and data rates may apply. Providing a mobile number and consenting to SMS messages are not required to receive medical treatment or services from WWMG. Reply HELP for help or STOP to opt out. View the WWMG Privacy Policy and SMS Terms and Conditions.

INITIALS VOICEMAIL #

PATIENT SIGNATURE ***DATE***
Type name for signature

For office use only
Dr._____ **Ins. code**_____ **Acct #**_____ **Initials**

WWMG Snohomish Family Medicine

Pediatric History Data Base

(0-12 yrs.)

Today's Date: _____

Patient's Name: _____ Birthdate: _____

Parent's Name: _____

List any medication allergies: _____

_____

List any long-term illnesses or surgeries: _____

_____

_____

_____

List any significant allergies or infectious diseases: _____

_____

_____

Family History:

	DOB	Health Condition
Father		
Mother		
Sibling		
Sibling		
Sibling		
Sibling		

Which relative has had the following:

_____ Diabetes
_____ Heart Attacks/Strokes
_____Allergies or Asthma
_____Epilepsy or Neurologic Condition
_____ Depression or Mental Illness
_____ Alcohol Problems
_____ Smokers in the Home
_____ High Cholesterol
_____ ADHD
_____ Other _____

Birth and Development History:

Any problems during pregnancy or delivery? _____

_____

Birthweight _____ Age at which patient rolled over _____ , Sat by self _____ , Walked _____, spoke first words _____. Any learning disabilities _____, behavior problems _____.

Check Below If Patient Has Ever Had:

o Diabetes	o Asthma	o UTI	o School Problems
o Hearing Loss	o Heart Murmur	o Joint Pain	o Depression
o Eye Problems	o Abdominal Pain	o Back Trouble	o Suicide Attempt
o Nasal Allergies	o Constipation	o Skin Problems	o Smoking Habit
o Multi Ear Infections	o Diarrhea	o Acne	
o Breathing Problems	o Bedwetting	o Eczema	

Immunization Dates – If you are not sure, please give approximation with question mark behind it.

Polio	__ / __ / __	MMR	__ / __ / __	Td Adult	__ / __ / __	**List Other**	**Date**
	__ / __ / __		__ / __ / __	Varicella	__ / __ / __	_____	__ / __ / __
	__ / __ / __	HIB	__ / __ / __		__ / __ / __	_____	__ / __ / __
	__ / __ / __		__ / __ / __	PCV	__ / __ / __	_____	__ / __ / __
DTaP	__ / __ / __		__ / __ / __		__ / __ / __	_____	__ / __ / __
	__ / __ / __		__ / __ / __		__ / __ / __	_____	__ / __ / __
	__ / __ / __	Hep B	__ / __ / __		__ / __ / __	_____	__ / __ / __
	__ / __ / __		__ / __ / __	Flu	__ / __ / __	_____	__ / __ / __
	__ / __ / __		__ / __ / __		__ / __ / __	_____	__ / __ / __

Date Reviewed: __ / __ / __ Reviewed By: _____

__ / __ / __ _____

__ / __ / __ _____

Please fill out this page if you are FEMALE. If you are not female, go to the next page.

Name: _____ **Date:** _____

DOB: _____

Review of Systems: Please checkmark any symptoms you are currently experiencing.

General
___ chills
___ daytime sleepiness
___ fatigue
___ fever
___ loss of appetite
___ malaise
___ night sweats
___ severe snoring
___ trouble sleeping
___ unexpected weight loss

Eyes
___ blurred vision
___ discharge
___ double vision
___ eye irritation
___ eye pain
___ light sensitivity
___ loss of vision

Ears, Nose, & Throat
___ decreased hearing
___ difficulty swallowing
___ ear discharge
___ earache
___ face or jaw pain
___ hoarseness
___ nasal congestion
___ nosebleeds
___ nasal discharge
___ ringing in the ears
___ sore throat

Cardiovascular
___ chest pain or discomfort
___ calf pain with walking
___ difficulty breathing at night
___ difficulty breathing laying down
___ fainting or near fainting
___ leg cramps
___ lightheadedness
___ discomfort breathing relieved by sitting or standing
___ palpitations or racing heart
___ hard time breathing when lying down
___ peripheral edema
___ recent weight gain
___ shortness of breath with exertion
___ swelling in extremities
___ syncope

Breast
___ abnormal mammogram
___ bloody discharge from nipple
___ breast enlargement
___ breast pain
___ breast lump
___ nipple discharge

Respiratory
___ chest pain with deep breaths
___ cough
___ coughing up blood
___ excessive mucus or phlegm
___ excessing snoring
___ excessive sputum
___ hemoptysis
___ pleuritic chest pain
___ shortness of breath
___ wheezing

Gastrointestinal
___ abdominal bloating
___ abdominal pain
___ bloody stools
___ change in bowel movements
___ constipation
___ black tarry stools
___ diarrhea
___ trouble swallowing
___ heartburn
___ hemorrhoids
___ indigestion
___ nausea
___ pain with swallowing
___ vomiting
___ vomiting blood
___ yellowish skin color

Genitourinary - Women
___ blood in urine
___ decreased sex drive
___ discharge
___ pain with urination
___ genital sores
___ heavy or prolonged periods
___ hot flashes
___ irregular or missed periods
___ nighttime urination
___ pain with intercourse
___ painful periods
___ pelvic pain
___ spotting
___ trouble starting urinary system
___ urinary frequency
___ urinary hesitancy
___ urinary urgency
___ urinary incontinence

Musculoskeletal
___ neck pain
___ thoracic pain
___ lumbar pain
___ general weakness
___ joint pain
___ joint swelling
___ muscle aches
___ muscle cramps
___ muscle weakness
___ stiffness

Skin
___ change in hair or nails
___ dry skin
___ excessive perspiration
___ itching
___ non-healing sores
___ rash
___ skin cancer
___ suspicious lesions
___ unusual hair distribution

Neurologic
___ arm or leg weakness
___ confusion
___ dizziness or sensation of spinning
___ facial weakness
___ falling down
___ headaches
___ loss of consciousness
___ numbness or tingling
___ poor balance or coordination
___ poor memory
___ seizures or uncontrolled movements
___ slurred speech
___ tremors
___ trouble concentrating
___ visual disturbances

Mental Health
___ depressed mood
___ anxious mood
___ fears or phobias
___ frightening visions or sounds
___ thoughts of suicide
___ thoughts of violence to others

Endocrine
___ intolerance to cold
___ intolerance to heat
___ excessive hunger
___ excessive thirst
___ excessive urination

Blood
___ enlarged glands
___ excessive or easy bruising
___ prolonged bleeding

Allergy
___ hives or rash
___ persistent infections
___ possible HIV exposure
___ seasonal allergies

Other:
_____

_____

Please fill out this page if you are MALE. If you are not male, go to the next page.

Name: _____ **Date:** _____

DOB: _____

Review of Systems: Please checkmark any symptoms you are currently experiencing.

General
___ chills
___ daytime sleepiness
___ fatigue
___ fever
___ loss of appetite
___ malaise
___ night sweats
___ severe snoring
___ trouble sleeping
___ unexpected weight loss

Eyes
___ blurred vision
___ discharge
___ double vision
___ eye irritation
___ eye pain
___ light sensitivity
___ loss of vision

Ears, Nose, & Throat
___ decreased hearing
___ difficulty swallowing
___ ear discharge
___ earache
___ face or jaw pain
___ hoarseness
___ nasal congestion
___ nosebleeds
___ nasal discharge
___ ringing in the ears
___ sore throat

Cardiovascular
___ chest pain or discomfort
___ calf pain with walking
___ difficulty breathing at night
___ difficulty breathing laying down
___ fainting or near fainting
___ leg cramps
___ lightheadedness
___ discomfort breathing relieved by sitting or standing
___ palpitations or racing heart
___ hard time breathing when lying down
___ peripheral edema
___ recent weight gain
___ shortness of breath with exertion
___ swelling in extremities
___ syncope

Breast
___ abnormal mammogram
___ bloody discharge from nipple
___ breast enlargement
___ breast pain
___ breast lump
___ nipple discharge

Respiratory
___ chest pain with deep breaths
___ cough
___ coughing up blood
___ excessive mucus or phlegm
___ excessing snoring
___ excessive sputum
___ hemoptysis
___ pleuritic chest pain
___ shortness of breath
___ wheezing

Gastrointestinal
___ abdominal bloating
___ abdominal pain
___ bloody stools
___ change in bowel movements
___ constipation
___ black tarry stools
___ diarrhea
___ trouble swallowing
___ heartburn
___ hemorrhoids
___ indigestion
___ nausea
___ pain with swallowing
___ vomiting
___ vomiting blood
___ yellowish skin color

Genitourinary - Men
___ blood in urine
___ decreased libido
___ discharge
___ pain with urination
___ erectile dysfunction
___ genital sores
___ nighttime urination
___ trouble starting urination
___ urinary frequency
___ urinary hesitancy
___ urinary urgency
___ urinary incontinence

Musculoskeletal
___ neck pain
___ thoracic pain
___ lumbar pain
___ general weakness
___ joint pain
___ joint swelling
___ muscle aches
___ muscle cramps
___ muscle weakness
___ stiffness

Skin
___ change in hair or nails
___ dry skin
___ excessive perspiration
___ itching
___ non-healing sores
___ rash
___ skin cancer
___ suspicious lesions
___ unusual hair distribution

Neurologic
___ arm or leg weakness
___ confusion
___ dizziness or sensation of spinning
___ facial weakness
___ falling down
___ headaches
___ loss of consciousness
___ numbness or tingling
___ poor balance or coordination
___ poor memory
___ seizures or uncontrolled movements
___ slurred speech
___ tremors
___ trouble concentrating
___ visual disturbances

Mental Health
___ depressed mood
___ anxious mood
___ fears or phobias
___ frightening visions or sounds
___ thoughts of suicide
___ thoughts of violence to others

Endocrine
___ intolerance to cold
___ intolerance to heat
___ excessive hunger
___ excessive thirst
___ excessive urination

Blood
___ enlarged glands
___ excessive or easy bruising
___ prolonged bleeding

Allergy
___ hives or rash
___ persistent infections
___ possible HIV exposure
___ seasonal allergies

Other:
_____

_____

Western Washington
Medical Group

1728 West Marine View Drive, Suite #110, Everett, WA 98201
www.wwmedgroup.com

Patient Name: _____ DOB: _____ MRN: _____

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 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, may be responsible for payments of interest on the unpaid balance of 9% 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 provider to release my information required to process my insurance claims and authorize my insurance company to make payment directly to my provider.

No show/Late Cancellation Fee: All WWMG clinics require a minimum 24-hour notice of any appointment cancellations or reschedules, including telehealth appointments. Fees may vary by clinic, please contact your provider's office for details. Late cancellation/no-show appointments will be charged:

- $50 for Primary Care and Imaging Center appointments/office visits
- $50 for Podiatry care center appointments/office visits
- $100 for Specialty care center appointments/office visits
- $150 for Psychology care center appointments/office visits
- $250 for surgeries, Endoscopy Center procedures, and in-office procedures

After 3 no-show appointments and/or late cancellations (with less than a full 24 hour notice to our clinics), you will be asked to leave the practice. Missed appointments take up valuable time that could be offered to another patient.

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name _____ DOB _____

Signature _____ Date _____

Western Washington Medical Group

WWMG
1728 W Marine View Drive #110, Everett, WA 98201
(425) 259-4041 Fax: (425) 252-6642

Registration Form Packet

Name: _____ DOB: _____ MRN: _____

Consent to Release Information to Friends and Family

I give the providers and office staff of Western Washington Medical Group (WWMG) permission to discuss my medical condition. *(NOTE: if a specific topic box is not checked, we will be unable to discuss <u>any</u> treatment related to that topic.)* **WWMG may disclose health care information regarding testing, diagnosis and treatment for the following conditions:**

☐ HIV (Aids virus)
☐ Sexually Transmitted Infections (STIs)
☐ Psychiatric disorders / Mental health
☐ Alcohol / Substance abuse
☐ All other health information
Other: _____

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* _____

<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 *<u>unless/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	**Second phone number**	**Third phone number**
Check one: Cell Work Home OK to leave detailed message?: Y N	Check one:Cell Work Home OK to leave detailed message?: Y N	Check one:Cell Work Home OK to leave detailed message?: Y N

_____ _____
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*

Western Washington Medical Group

WWMG
1728 W Marine View Drive #110, Everett, WA 98201
(425) 259-4041 Fax: (425) 252-6642

Registration Form Packet

Name: _____ DOB: _____ MRN: _____

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: _____

_____ _____

Employee Name *Date*

This form will be retained in your medical record

Western Washington Medical Group

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home, office, or cell phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no,” for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html.**
- We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care or payment for your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

If we have your substance use disorder patient records, subject to 42 CFR part 2, we will give you clear and obvious notice in advance and a choice about whether to receive fundraising communications that use your Part 2 information.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways:

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

In all cases, including those listed below, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions/ Information Related for Notice

- Effective Date of this Notice: 08/06/2026

- Melissa Danielson, Compliance Officer (425) 259-4041.

- **Marketing Communications; Sale of PHI**.
  We must also obtain your written authorization prior to using or disclosing PHI for marketing purposes or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

- **Psychotherapy Notes**:
  We must also obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes; (2) for our own training programs in which mental health students, trainees or

practitioners learn under supervision to practice or improve their counseling skills; (3) to defend ourselves in a legal proceeding initiated by you; (4) as required by law; (5) by a health oversight agency with respect to the oversight of the originator of the psychotherapy notes; (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

- **Uses and Disclosures of Your Highly Confidential Information**:
  In addition, federal and state law requires special privacy protections for certain highly confidential information about you, including the subset of your PHI that: (1) is about mental health and developmental disabilities services; (2) is about alcohol and drug abuse prevention, treatment and referral; (3) is about HIV/AIDS testing, diagnosis or treatment; (4) is about venereal disease(s); (5) is about genetic testing; (6) is about child abuse and neglect; (7) is about domestic abuse of an adult with a disability; or (8) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

- **Use of PHI for Research**:
  For Research. Medical research is vital to the advancement of medical science. Federal regulations permit use of protected health information in medical research. Our clinical researchers may look at your health records as part of your current care, or to prepare, or conduct research. All patient research conducted at Western Washington Medical Group is reviewed and approved by an Institutional Review Board before any medical research study begins. You may opt out of being contacted to participate in clinical research by contacting the Privacy Officer at (425) 259-4041.

- **Use of PHI for Operations**:
  We may use technologies, including artificial intelligence tools, to assist our clinicians with documentation and care delivery. These tools are subject to appropriate privacy and security protections. You may request alternative documentation approaches where available.

- **Use of PHI with Business Associates**:
  We may share your information with business associates who perform services on our behalf, who are required to protect your information.

- **De-Identified Information**: We may use your health information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law without your authorization or consent, including but not limited to, research studies, use or development of artificial intelligence tools and other advanced technologies, and health care/health operations improvement activities.

- We provide our patients with access to their health information using an **online portal**.

- **SMS Communications and Mobile Information:**
  Western Washington Medical Group ("WWMG") may collect mobile telephone numbers, SMS communication preferences, opt-in consent, opt-out requests, message interactions, and related information when individuals enroll in or use the WWMG text messaging program.
  WWMG uses this information to send non-marketing communications regarding appointment reminders, appointment confirmations, scheduling, cancellation or rescheduling, patient onboarding, care-related administrative notifications, billing, account updates, and customer support.
  Mobile information, including mobile telephone numbers and SMS opt-in consent, will not be sold, rented, or shared with third parties or affiliates for marketing or promotional purposes.
  WWMG may disclose mobile information to service providers and business associates that assist WWMG in operating and delivering the text messaging program. Information is disclosed only as necessary to provide those services and remains subject to applicable contractual, privacy, and security requirements.
  Message frequency varies. Message and data rates may apply. Reply STOP to any WWMG text message to opt out or reply HELP for assistance.
  Opting out of SMS messages does not affect the ability to receive medical treatment or services from WWMG. Communications may continue through other channels based on the patient's communication preferences and as permitted by law.