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, which may contain details of my medical condition on my voicemail box if they are unable to reach me.

INITIALS VOICEMAIL #

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

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

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: _____

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.

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

Printed Name_____DOB_____

Signature_____Date_____

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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*

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WWMG
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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

Notice of Privacy Practices

The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. A federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

Please take a moment to review our Notice of Privacy Practices. We also request that you sign and return the attached Acknowledgement of Receipt of Notice of Privacy Practices documenting that you received a copy of our Notice.

If you have any questions about this Notice please contact the Care Center Manager at your provider's office, or our Privacy Officer at (425) 259-4041.

WESTERN WASHINGTON MEDICAL GROUP

NOTICE OF PRIVACY PRACTICES

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.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time).

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures without Your Written Authorization We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law. 1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI including your medication history to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

2. Payment: We may use or disclose PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include information about a surgery you received so that the insurer will pay us for the surgery. We may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment. 3. Health Care Operations: We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff. We may also disclose PHI to our health care professionals for review and learning purposes. Western Washington Medical Group is part of a HIPAA organized health care arrangement ("OHCA") with participating providers of the Physician Care Alliance. As participants in the OHCA, Western Washington Medical Group and the other OHCA participants engage in quality assessment and improvement activities through which treatment provided by each organization is assessed by the other participants. As permitted by HIPAA, Western Washington Medical Group may share the health information of its patients with the OHCA participants when necessary for health care operations purposes of the OHCA.

4. Required or Permitted by Law: We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including

disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures for workers' compensation claims; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as otherwise as authorized by law.

5. Fundraising. We may contact you for the purpose of raising funds for our own benefit. We may also disclose PHI to a foundation that is related to us so that the foundation may contact you in an effort to raise funds for our benefit. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

B. Permissible Uses and Disclosures That May be Made Without Your Authorization, But for Which You have an Opportunity to Object.

1. Family and Other Persons Involved in Your Care. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

2. Disaster Relief Efforts. We may use or disclose PHI to a public or private entity authorized by law or its charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

C. Uses and Disclosures Requiring Your Written Authorization.

1. 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.

2. 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.

3. 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.

4. Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to

sign an authorization form before we can send PHI to your life insurance company, to a school, or to your attorney. You may revoke any such authorization at any time by providing us with written notification of such revocation.

II. YOUR INDIVIDUAL RIGHTS A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested.

B. Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI we use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to any such restriction you may request, except if your request is to restrict disclosing PHI to a health plan for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the PHI pertains solely to a health care item or service which has paid in full by you or another person or entity on your behalf.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us subject to certain restrictions and limitations. E. Right to Request Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to our Privacy Officer at any time.

G. Right to Receive Notification of a Breach. We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.

H. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the Privacy Officer at (425) 259-4041. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or our Privacy Officer.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on January 24, 2019.

B. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site at www.wwmedgroup.com. You may also obtain any revised notice by contacting the Privacy Officer at (425) 259-4041.