UNIBE Care Family Medicine

13100 Military Road S. Suite #1 & 2
Tukwila, WA 98168
(206)242-7333

Thank you for selecting us as your care provider. To serve you properly, please complete this patient registration form clearly. All information will be confidential. Please present your ID and insurance cards to be copied for file. Thank you.

PATIENT PERSONAL INFORMATION					
Patient Name	First Name	Middle Initials	Last Name		☐ Male ☐ Female
Race	Ethnicity		Language	Date of birth	/ /
Home Address				Social Security #	- -
City		State	Zip	Mobile Phone #	( ) -
Home Phone #	( ) -	Email		Work Phone #	( ) -
Employer		Occupation		☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor	
Work Address					
City		State	Zip		
If Patient is under 18 years old, person providing the information is the minor's?			☐ Parent	☐ Guardian	
Name			Relationship to patient		
In case of emergency, please contact					
Name	First Name	Middle Initials	Last Name	Relationship to patient	
Address				Home phone #	( ) -
City		State	Zip	Mobile phone #	( ) -

INSURANCE PROVIDER INFORMATION			
Insurance covered under through	☐ Work Insurance	☐ Other (please give us more information on the Insured)	
Insurance company		Name of insured	
Employer name		Relationship to patient	
Work phone #		Insured's date of birth	/ /
Date employed		Insured's Social Security #	- -
Insurance ID #		Copay amount	Deductible amount
My additional insurance provider information			
Insurance covered under through	☐ Work Insurance	☐ Other (please give us more information on the Insured)	
Insurance company		Name of insured	
Employer name		Relationship to patient	
Work phone #		Insured's date of birth	/ /
Date employed		Insured's Social Security #	- -
Insurance ID #		Copay amount	Deductible amount

FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT (This is applicable even to those who have insurance)					
Person responsible for this account	First Name	Middle Initials	Last Name	Date of birth	/ /
Address				Home phone #	( ) -
City		State	Zip	Mobile phone #	( ) -
Relationship to patient			Is this person a patient of our office?	☐ Yes	☐ No

I authorize the physicians of UNIBE Care Family Medicine (UNIBE) to provide any medical care deemed necessary according to their professional opinion. I understand that I am financially responsible for this account unless other arrangements are made. In the event that charges are not covered by my insurance plan benefits, I will be held accountable for making payments that are considered patient's responsibility. I authorize my insurance benefits to be paid directly to UNIBE and the release of any information by UNIBE to my insurance carrier pertinent to my health insurance claims.

Name of patient or parent/guardian (if minor) ____________________

Signature of patient/parent/guardian (if minor) ____________________ Date ___/___/___

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Patient Name ______________________ Date of Birth ___/___/___ Today's Date ___/___/___

HEALTH HISTORY	
List your chronic medical conditions	**List your allergies**

List all of your current medications you are taking, including over the counter medications

List your hospitalization and operations	
Date	Reason

Family History (Indicate relationship of who has/had this, e.g., mother, father, sister, brother, etc)			
Diabetes		Seizures	
High Blood Pressure		Cancer	
Heart Disease		Stroke	
Thyroid Disease		Allergies	
Arthritis		Alcoholism	
Mental Illness		Tuberculosis	
Other			

When was your last complete physical exam?			
When was your last tetanus shot?			
Do you smoke?	☐ Yes ☐ No	If yes, how much per day?	
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much per day?	
Do you use or have you ever used illicit drugs?	☐ Yes ☐ No		
Do you have a history of sexually transmitted diseases?	☐ Yes ☐ No		

Female patients only:

When was your last pap smear?		**Did you have an abnormal pap smear?**	☐ Yes ☐ No
When was your last mammogram?			

What is the reason for your visit today?

Are there any medical problems that you are concerned about today?

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PATIENT RIGHTS AND RESPONSIBILITIES

You have the right to:

- Be treated with respect and recognition of your dignity and right to privacy
- Confidential handling and access to your medical records and protected health information
- Complete information regarding your health and medical services
- Participate in decision making about your health care
- Ask about fees, charges and policies concerning payments
- Refuse to participate in research
- Complain about any clinic services

You are responsible for:

- Providing information needed by your healthcare provider in order to provide health care for you
- Keeping scheduled appointments and giving appropriate notice when cancelling appointments
- Following treatment plans and instructions for care as agreed to with your healthcare provider
- Treating staff and other patients with respect
- Respecting the privacy of others
- Paying for services rendered, in the events when coverage is not in effect or when payment is patient responsibility as determined by insurance provider
- Supervising and maintaining the safety of your children who accompany you to the clinic

I understand the Patient Rights and Responsibilities of UNIBE Care Family Medicine (UNIBE).

Patient Name ____________________________ Date of Birth _______/_______/_______

Signature of patient/parent/guardian (if minor) ____________________ Date _______/_______/_______

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

UNIBE Care Family Medicine (UNIBE) and its medical staff members are independently responsible of complying with the Notice of Privacy Practices only with respect to health information created for services generated at UNIBE. We are not responsible for each other's actions and do not have equal control over the other's business. If you have a question regarding the information set forth in the Notice of Privacy Practices, please do not hesitate to call us at (206) 242-7333.

The Notice of Privacy Practices describes your legal rights regarding your protected health information (PHI) and the disclosure of PHI needed for patient care and other important purposes.

I understand that as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand that the Notice of Privacy Practices that provides a more complete description of information uses and disclosures has been made available to me.

I understand UNIBE reserves the right to change its notices and practices and prior to implementation and will mail a copy of any revised notices to the address that I have provided.

I understand that I have right to request restrictions as to how my health information may be used and disclosed to carry out treatment, payment or health care operations and that UNIBE is not required to agree to the restrictions requested.

I understand that this consent has no expiration date and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my PHI:

____

____

If you have declined a copy of this Notice, please initial here and sign below: ______________________

I have been notified of the Notice of Privacy Practices of HIPAA and consent to the use and disclosure of my protected health information for treatment, payment and health care operations.

Patient Name ______________________________ Date of Birth ____/____/____ Date ____/____/____

Signature of patient/parent/guardian (if minor) ______________________________

FOR OFFICE USE ONLY

Witnessed by (staff name) ______________________________

Date ______________________________

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.

UNIBE Care Family Medicine (UNIBE) and its medical staff members are committed to protecting the privacy of your protected health information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we provide you with the Notice of Privacy Rights which lets you know how your health information may be used or disclosed and describes your rights regarding the information we have in our possession.

USES AND DISCLOSURES RELATING TO TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

Treatment: Your PHI may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to health professionals and staff who may be involved with your care.

Payment: Your PHI may be used to seek payment from your health plan or other sources of coverage for the service provided to you. For example, your health care plan may request and receive information on dates of service, the services provided, and the medical condition being treated. We may also provide your health information to our billing and claims processing companies that process our health care claims.

Health care operations: Your PHI may be used as necessary to support the activities and management of UNIBE. For example, information on the services you receive may be used to support budgeting and financial needs, and to evaluate and promote quality of care.

Other permitted or required disclosures

HIPAA permits us to use or disclose your PHI for other purposes without your consent or authorization for the following reasons

Law enforcement: Your PHI may be disclosed when required by law to law enforcement agencies to support government audits and inspections, and to comply with government-mandated reporting.

Public health reporting: Your PHI may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Health oversight activities: Your PHI may be disclosed to government oversight agencies.

Research, death, organ donation: In certain circumstances, we may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your PHI if we believe disclosure is necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Process and Proceedings: We may disclose your PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Military and National Security: We may disclose to Military authorities the PHI of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials PHI required for lawful intelligence, counterintelligence, and other national security activities.

Other uses and disclosures may require your authorization. Disclosure of your PHI or its use for any purpose other than those listed above may require your specific written authorization. You may submit a written revocation of the authorization, however, this would not undo or affect any disclosure that occurred before your decision to revoke authorization.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to your PHI: You have the right to look at and get a copy of your PHI, except in certain limited circumstances. You may request to review and/or obtain a copy of you PHI records which must be made in writing. We may charge you a nominal fee for providing you with copies of your PHI. Also, we may limit the access based upon a belief that it could harm you or another person. You have the right to request a review of that decision.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must identify the information that you think is incorrect and explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Accounting of Disclosures: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations, and certain other activities. You are entitled to such an accounting for the 6 years prior to your request, though not for disclosure made prior to April 14, 2003. We will provide you with the date on which we made a disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI for treatment, payment, health care operations or to persons you identify. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. If you advise us that disclosure of all or any part of your PHI could endanger you, we must comply with any reasonable request provided it specifies an alternative means or location of communication.

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

If you believe that your privacy rights have been violated, you may file a complaint with us at (206) 242-7333 and/or by calling the Secretary of the Department of Health and Human Services at 1-877-696-6775.

This notice has an effective date of April 14, 2003.

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Financial Policies and Procedures

Here at UNIBE Care Family Medicine, we believe that all patients that are taken care of by this clinic deserve the best medical care that can be provided. In order for us to provide our patients with the highest quality of medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met on a timely basis, this agreement will inform you about our financial policies.

Payment at time of service, Fees, and Collections

The insurance policy that you have is a contract between you and your insurance company. As a courtesy, we will file your insurance claim on your behalf for all your office visits. However, we will not become involved in disputes between you and your insurance company. This includes, but not limited to; deductibles, copayments, and non-covered charges. You are ultimately responsible for timely payment of your account, regardless of how much your insurer pays.

Please have your payment of copay ready at time of service rendered. Under Washington State Law (RCW 48.30A.015) we are required to obtain payment. Should you not be able to pay your copayment at check-in, you will be billed the copayment amount and be expected to pay within 72 hours or 3 business days starting the day the bill was sent.

It is your responsibility to provide us with your current insurance card and information prior to every visit so that we may be able to bill your insurance company efficiently. It will be reviewed or copied every time you come, no matter how frequently you are seen. If a claim is rejected due to an expired policy or a service that is not covered, you are ultimately responsible of the outstanding balance. You are ultimately responsible to understand and know what kind of services your insurance covers. Due to a large variety of insurance plans, it is impossible for us to know what services are covered for every single individual. Please educate yourself as to what kind of coverage you have so the office visits, immunizations, testing and specialist referrals can be tailored to meet your needs.

Payment

We accept cash, checks, and all major credit cards. You will receive a receipt for your transaction. Please keep this for your records should an issue occur. We reserve the right to charge a $30 charge towards the account's balance for each returned check.

Uninsured/Self-pay

We offer a special sliding scale fee schedule to all of those that are self-pay patients. The fee schedules are predetermined. Full payment is expected for all visits. Addition charges; e.g. lab work, physicals, vaccinations, will be notified to you in advance. Payment is expected at the time of service is rendered.

Lab Work

There are some lab works that we cannot perform at this facility. Should you receive a bill pertaining to lab work, please call the number on your bill for inquiry. You are ultimately responsible for any outstanding balance you receive for services outside of the clinic.

MVA/3rd Party Insurance

With regards to MVA cases, we will only accept these cases for established patients. We will only bill PiP (Personal Injury Protection) and third party insurance companies. We will not bill health insurance(s) as we want to keep these matters separate to decrease complications in these processes. It is ultimately the patient's responsibility for the remaining balance.

Payment Arrangements

Under special circumstances, payment arrangements may be made. In order to obtain payment arrangements, you must contact us pertaining to your situation. These arrangements will be set up to tailor to each individual's needs. Our billing department will send a monthly bill, however, if you miss a single payment, your account will be considered to be sent to collections. Please be aware that these arrangements are not made for every individual. It is your responsibility to contact us for any concerns you have pertaining to your balance.

Outstanding Balance and Non-payment

Any account that has an outstanding balance and is past due by 60days, will be considered as delinquent. As such, these accounts will be subjected to additional fees and interest fees. Such accounts are subject to interest charges of 1.5% per month and may be sent to our collection agency, attorney review, and possible district court collections proceedings. If your account is considered delinquent and also sent to the collection agency or district court, you are ultimately responsible for all court fees associated with collections on your account. We reserve the right to charge an additional 25% collection charge to your balance. Once your account is sent out to collections, attorney review, and/or district court collections, we will no longer be able to handle your account; any inquiries should be through the respective agency. Should your account be sent to collections, you are required to settle the balance with the collection agency before we can be able to see you.

Assignment of Benefits

I request that the payment of authorized Medicare, Apple Health (Medicaid), and commercial insurance benefits be made on my behalf to the name of the provider of service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Apple Health (Medicaid) Services and its agents, or any other insurer and its agents, any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to UNIBE Care Family Practice for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance or this assignment.

x________ Initial Here

Authorization to Release Information

I hereby authorize UNIBE Care Family Medicine to: (1) release any information necessary to insurance carriers regarding my illnesses and treatments: (2) process insurance claims generated in the course of examinations or treatments: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime. This order will remain in effect until revoked by me in writing.

x________ Initial Here

By signing this document, I, ____________________________, hereby agree that I have understood and accepted the financial policies and procedures of UNIBE Care Family Practice.

_________________________ Print Patient Name

____________ Date of Birth

x___________________________ Signature of Patient or Guardian

____________ Date

__________________________ Relationship to Patient