Patient Information Form

Name:_____ DOB:_____ Appt. Date:_____

Address: <_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Gender:_____

DOB:_____ **Email Address:**_____

Employer Name:_____ Work Phone:_____

Are you coming in for a work-related injury? ☐ **Yes** ☐ **No** **IF YES, DATE OF INJURY:**_____

REQUIRED - Primary MEDICAL physician (FULL name):_____

☐ **CHECK BOX IF PRIMARY REFERRED YOU**

Other Referring provider **IF NOT YOUR PRIMARY CARE PHYSICIAN**:_____

Eye Doctor:_____

Emergency Contact

Name:_____ Relationship: ☐ Spouse ☐ Parent/Guardian Other:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Financial Responsibility Acknowledgment

I understand and agree with the following:

I am financially responsible for all charges not covered by my insurance, including **co-pays, deductibles, non-covered services, and denied claims**.

Payment is due at the time of service unless prior arrangements are made.

If my account becomes **delinquent** (unpaid beyond 90 days), it may be **referred to a third-party collection agency**.

Notice of Collections Policy

In accordance with **Washington State law (RCW 19.16 and RCW 70.01.040)**:

If my account remains unpaid after reasonable attempts to collect payment, the provider may refer the balance to a **licensed third-party collection agency**.

I may be responsible for any **reasonable collection fees**, **court costs**, and **attorney's fees** as permitted by law.

I acknowledge that I have been informed of this policy and understand that failure to pay may result in collections action.

_____ Date:_____

Signature of Patient or Guardian

Primary Insurance

Company Name:_____ Policy #:_____ Group ID: <_____

IF RESPONSIBLE PARTY IS SOMEONE BESIDES THE PATIENT, PLEASE FILL IN THE FOLLOWING:

Policy holder's name:_____ **DOB**:_____

Relationship to patient: ☐ Spouse ☐ Parent / Guardian ☐ Other: _____

Phone #:_____ DOB:_____

Secondary Insurance

Company Name:_____ Policy #:_____ Group ID: _____

IF RESPONSIBLE PARTY IS SOMEONE BESIDES THE PATIENT, PLEASE FILL IN THE FOLLOWING:

Policy holder's name:_____ **DOB**:_____

Relationship to patient: ☐ Spouse ☐ Parent / Guardian ☐ Other: _____

Phone #:_____ DOB:_____

What is the nature of your visit?_____

_____

Section I: Surgery and Anesthesia History

Have you ever had surgery? ☐ Yes ☐ No

IF YES, PLEASE LIST:_____

_____

_____

Section II: Specific Medical History

Height:_____
Weight:_____

HEALTH HISTORY	Yes	No
Asthma	☐	☐
High Blood Pressure	☐	☐
Heart Trouble	☐	☐
Hepatitis or Liver Trouble	☐	☐
Kidney Trouble	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
HIV / AIDS	☐	☐
Cancer	☐	☐
Thyroid Trouble	☐	☐
Arthritis	☐	☐

Rheumatic Fever	☐	☐
Anemia	☐	☐
Tuberculosis	☐	☐
High Cholesterol	☐	☐
Glaucoma	☐	☐
Stomach Ulcer	☐	☐
Bleeding Tendency	☐	☐
Atrial Fibrillation	☐	☐

Others not listed:_____

Section III: Social History

Do you smoke? ☐ Yes ☐ No If Yes, how much?_____

Section V: Medications

Are you taking any medications, vitamins, or herbal supplements? ☐ Yes ☐ No

IF YES, PLEASE LIST:_____

_____

_____

Section VI: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ Yes ☐ No

IF YES, PLEASE LIST:_____

_____

_____

Preferred PHARMACY:_____

We do not use online or mail pharmacies.

Location / phone number:_____

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature:_____ Date:_____

Consent to Communicate

Patient:_____

Please mark the ways that you consent to communicate with you:

Method	OK to Leave Voicemail	OK to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call**
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Send Email			☐	
☐ Email Appointment Reminders				
☐ Email Office Specials				
☐ Send Regular Mail				
Mail to which Address: ☐ Home ☐ Other (PLEASE LIST BELOW):				
☐ Send Text Message – if so, list cell carrier:				
☐ Text Appointment Reminders				
☐ Text Special Offers and birthday specials				

** Best time to call examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

I give the physician and staff of Kristin J Tarbet MD permission to share and/or release information to:

Name	DOB	Relationship	OK to Release Results
Any Comments:			

Name	DOB	Relationship	OK to Release Results
Any Comments:			

_____ Date:_____

Signature:

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to people other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We can do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communication informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions on the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement with the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Print Name _____ Date _____

Signature _____