



## PATIENT INTAKE FORM

Please complete all sections as accurately as possible. All information is confidential.

### PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Date of Birth/Age: \_\_\_\_\_ Sex Assigned at Birth: \_\_\_\_\_ Gender Identity \_\_\_\_\_  
 Preferred Pronouns \_\_\_\_\_ Race / Ethnicity \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
**REQUIRED - Primary Care Physician (PRIMARY DOCTOR'S NAME):** \_\_\_\_\_  
 Referring Provider (if different): \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### INSURANCE INFORMATION

Primary \_\_\_\_\_ Policy # \_\_\_\_\_ Group ID: \_\_\_\_\_  
**Policy Holder (if not patient)** \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Secondary \_\_\_\_\_ Policy # \_\_\_\_\_ Group ID \_\_\_\_\_  
**Policy Holder (if not patient)** \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_ 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.

It is my responsibility to inform Dr. Tarbet's office of any changes to my insurance, address, or other information.

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

Patient Name (Printed): \_\_\_\_\_ Patient Signature \_\_\_\_\_

### PREFERRED PHARMACY

**Preferred Pharmacy Name:** \_\_\_\_\_

**Pharmacy Location / Phone:** \_\_\_\_\_

**PAST MEDICAL CONDITIONS**

Asthma  Yes  No

High Blood Pressure  Yes  No

Heart Disease  Yes  No

GERD  Yes  No

Diabetes  Yes  No

High Cholesterol  Yes  No

Thyroid Disease  Yes  No

Stroke  Yes  No

Anxiety Disorder  Yes  No

Depression  Yes  No

COPD  Yes  No

Arthritis  Yes  No

Atrial Fibrillation  Yes  No

Kidney Disease  Yes  No

Liver Disease  Yes  No

Epilepsy  Yes  No

**Other Conditions** \_\_\_\_\_

**Notes** \_\_\_\_\_

**OCULAR HISTORY**

Glaucoma  Yes  No

Macular Degeneration  Yes  No

Retinal Detachment  Yes  No

Dry Eye  Yes  No

Cataracts  Yes  No

Floaters / Flashes  Yes  No

Eye Injury  Yes  No

Laser Treatment  Yes  No

Retinal Tear  Yes  No

Eye Infection  Yes  No

Vision Loss  Yes  No

Wears Glasses  Yes  No

Wears Contacts  Yes  No

**Additional Outside Imaging** \_\_\_\_\_

**OCULAR SURGICAL HISTORY**

*List prior eye surgeries and dates:*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SURGERIES (NON-OCULAR)**

*List prior surgeries and dates:*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SOCIAL HISTORY**Current Smoker  Yes  NoFormer Smoker  Yes  NoE-Cigarette Use  Yes  NoAlcohol Use  Yes  NoDrug Use  Yes  NoCaffeine Use  Yes  NoDrives  Yes  NoRecent Falls  Yes  No**PSYCHOSOCIAL SCREENING**Feeling Down / Depressed  Yes  NoLittle Interest / Pleasure  Yes  NoAnxiety  Yes  NoPTSD  Yes  NoHigh Stress Level  Yes  No**FAMILY HISTORY**Glaucoma  Yes  NoMacular Degeneration  Yes  NoRetinal Detachment  Yes  NoDiabetes  Yes  NoHeart Disease  Yes  NoHypertension  Yes  NoCancer  Yes  No**Other Family Conditions** \_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS***List all medications, vitamins, and supplements (including dosage if known):*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES****Drug Allergies** \_\_\_\_\_**Other Allergies** \_\_\_\_\_**Reaction(s)** \_\_\_\_\_**Patient Name (Printed):** <PersonalInfo.FirstName> <PersonalInfo.LastName> \_\_\_ **Date** \_\_\_\_\_**Patient Signature** \_\_\_\_\_

\_\_\_\_\_

### CONSENT TO COMMUNICATE

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

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
<input type="checkbox"/> Call Work Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Cell Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Call Home Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	
<input type="checkbox"/> Send Email	—		<input type="checkbox"/>	—
<input type="checkbox"/> Email Appointment Reminders <input type="checkbox"/> Email Office Specials				
<input type="checkbox"/> Send Regular Mail	—		<input type="checkbox"/>	—
Mail to which Address: <input type="checkbox"/> Home <input type="checkbox"/> Other (please list): _____				
<input type="checkbox"/> Send Text Message			<input type="checkbox"/>	—
<input type="checkbox"/> Text Appointment Reminders <input type="checkbox"/> Text Office Specials				
<b>*Best Time to Call Examples:</b> <i>morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message</i>				

#### RELEASE OF INFORMATION

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
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

## Notice of Privacy Practices (NPP)

**Effective Date:** February 16, 2026

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy and the confidentiality of your health information. Our practice has long been committed to protecting patient privacy. This Notice of Privacy Practices explains how we may use and disclose your Protected Health Information (PHI), your rights regarding that information, and our legal duties.

This Notice applies to all records of your care maintained by this practice. A more complete copy of this Notice is available upon request and is posted in our office.

### Our Legal Duties

We are required by law to:

- Maintain the privacy of your PHI
- Provide you with this Notice explaining our legal duties and privacy practices
- Follow the terms of the Notice currently in effect

### How We May Use and Disclose Your Health Information

#### Treatment, Payment, and Health Care Operations (TPO)

We may use and disclose your PHI as necessary for treatment, payment, and health care operations. This includes sharing information with other health care providers, laboratories, and insurance carriers involved in your care.

#### Administrative and Operational Use

Patient records may be stored in administrative areas such as examination rooms or front-office workspaces as part of normal office operations. These records are accessible only to authorized staff and do not contain publicly visible coding identifying your condition.

#### Appointment Reminders and Practice Communications

We may contact you to remind you of appointments or provide information about office policies, scheduling, or services. Contact may occur by telephone, voicemail, text message, email, U.S. mail, or other methods you authorize.

#### Business Associates

We may share PHI with vendors or contractors (business associates) who assist us with operations such as billing, electronic health records, or information technology. These parties are required by law to safeguard your information.

#### Legal and Regulatory Disclosures

We may disclose PHI as required by law, including to health oversight agencies, insurance payers, or government authorities during audits, inspections, or investigations.

#### Special Protections for Substance Use Disorder (SUD) Records

This practice provides medical and cosmetic care only and does not operate a substance use disorder treatment program. However, to the extent that substance use disorder (SUD) information is documented within your medical record, that information is subject to **additional federal and Washington State confidentiality protections**.

- SUD-related information may not be disclosed or redisclosed except as permitted by law.
- Even when used or disclosed for treatment, payment, or health care operations, **redisclosure of SUD information is limited**.
- SUD information may not be used to investigate or prosecute a patient in criminal, civil, administrative, or legislative proceedings without a qualifying court order.
- Law enforcement access to SUD information is strictly limited.

Any recipient of SUD-related information is prohibited from redisclosing it unless expressly permitted by law.

### Patient Rights

You have the right to:

- Access and obtain a copy of your medical records, subject to applicable laws
- Request amendments to your records
- Request restrictions on certain uses or disclosures of your PHI (we are not required to agree to all requests)
- Request confidential communications by alternative means or locations
- Receive an accounting of certain disclosures
- Receive a paper copy of this Notice upon request
- File a complaint if you believe your privacy rights have been violated

Under Washington State law, you may have additional rights related to the confidentiality of health care information, including mental health and substance use disorder records.

You will not be retaliated against for filing a complaint.

### **Marketing and Fundraising**

Your PHI will not be used for marketing or advertising purposes without your written authorization.

### **Changes to This Notice**

We reserve the right to change the terms of this Notice at any time. Changes will apply to all PHI we maintain and will be made available in our office and upon request.

### **Questions or Complaints**

If you have questions, concerns, or complaints regarding your privacy rights, please contact the office manager or your physician.

You may also file a complaint with:

- **U.S. Department of Health and Human Services, Office for Civil Rights (OCR)**
- **Washington State Office of the Attorney General** under the Washington Uniform Health Care Information Act (RCW 70.02)

Filing a complaint will not affect your care.

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\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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*Thank you for completing your intake form.*