Deer Park Family Care Clinic

Account Number:_____

Last Name:_____ Middle Initial: _____First Name:_____

Date of Birth:____/____/_____ Sex: M F SSN:_____ E-mail:_____

Mailing Address:_____ City: _____State:_____ Zip:_____

Physical Address:_____ City:_____ State:_____ Zip:_____

Primary Phone Number (____) _____ Other Phone Number: (____) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment Status: ☐ Employed ☐ Retired ☐ Student ☐ Part Time ☐ Full Time

Race:_____ Ethnicity: ☐ Hispanic ☐ Non- Hispanic

PERSON RESPONSIBLE FOR ACCOUNT/PATIENT

*If patient is responsible for own account, just put SELF

Last Name: _____Middle Initial: _____ Last Name: _____

Birth Date: ___/____/____ Sex: ☐Male ☐ Female Social Security #: _____

Primary Phone: (____)_____Other Phone: (___)_____ Relation to Patient: _____

EMERGENCY CONTACT INFORMATION

Last Name:_____ First Name:_____

Relationship: _____ Phone Number: (____) _____

Last Name:_____ First Name:_____

Relationship: _____ Phone Number: (____) _____

Is this a work related injury?

Yes / No

Date of injury

___/___/___

I certify that all information reported is true and correct. I authorize the release of any necessary information, including medical information, for this or any related claim, to the insurance carrier and/pr primary Doctor. In making this assignment, I authorize payment be made directly to Deer Park Family Care from my insurance company. I Understand and agree that I am financially responsible for co-pays and deductibles at the time of service. Any charges not paid by the insurance company will become my responsibility and is due immediately.

_____ _____ _____

Signature of Person Financially Responsible Date Accepted By

Deer Park Family Care Clinic

Release of Information to
Spouse/Relatives/Friends
Deer Park Family Care Clinic

I give permission for these specified persons to obtain/request/discuss any of my medical/billing information during the duration of my time here as a patient at Deer Park Family Care Clinic. I understand that any time during this period I can revoke the privileges to the assigned names below and will inform DPFCC staff of any deletions or additions to the persons allowed to receive my medical information. Once health care information is disclosed, the person that receives it may re-disclose it, and privacy laws may no longer protect it. This contract will **expire in one year** and will need to be filled out and updated one year from the signed date. Any information I **do not** want disclosed (STD, substance abuse, mental health information, HIV, pregnancy, sterilization or other information) will be written in the comment section below.

Name:_____Phone:_____Relation:Spouse/Sig.Other_

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

Name:_____Phone:_____Relation:_____

Comments:_____
_____
_____
_____
_____
_____

Would you like us to leave you detailed messages on your primary phone number answering machine? Yes_____ No_____

Signature: _____Date:_____

Print Patient Name: _____DOB: _____

Deer Park Family Care Clinic

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Please send records to: Deer Park Family Care Clinic
Attention: Megan M
P.O. Box 1529
Deer Park, WA 99006

Phone (509) 276-5005 Fax (509) 276-7785

PATIENT INFORMATION:

Patient Name: _____ Birth Date: _____

I AUTHORIZE DEER PARK FAMILY CARE CLINIC (DPFCC) TO:

( ) Obtain health information from: _____
(Facility, provider, other)

Address: _____

Phone Number: _____ Fax Number: _____

( ) Release my information **from** DPFCC **to**: _____
(Facility, provider, other)

Address: _____

Phone Number: _____ Fax Number: _____

PURPOSE OF DISCLOSURE:

( ) Transfer of care ( ) Moving ( ) Legal ( ) Coordination of Care ( ) Other: _____

INFORMATION TO BE RELEASED:

Date of records requested: _____

( ) Last 3 office visits ( ) Hospital Reports ( ) EKG's
( ) Labs ( ) X-rays ( ) Immunizations ( ) Recent History & Physical

EXPRESSEDS CONSENT:

I specifically DO NOT authorize the release of information for the categories checked below:

( ) Substance abuse information ( ) Mental health information ( ) Pregnancy
( ) Sexually transmitted diseases ( ) HIV related information ( ) Sterilization

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I do revoke the authorization, it will not affect any actions already taken by Deer Park Family Care Clinic based up this form. Once health care information is disclosed, the person or organization that receives it may re-disclose it, and privacy laws may no longer protect it. By authorizing the release of this information, I understand that my health care and payment for my healthcare will not be affected. This authorization will expire one year from the date signed unless otherwise specified.

_____ _____
Patient or Legally Authorized Individual Signature Date

Deer Park Family Care Clinic

DEER PARK FAMILY CARE CLINIC
HIPAA NOTICE OF PRIVACY PRACTICE

The HIPAA privacy rules impose upon covered entities specific requirements, which are designed to ensure that an entity does not use or disclose a person's private health information except as permitted or required by the rules. In general, the requirements imposed on medical personnel under HIPAA are:

(1) To notify patients about their privacy rights, and about how their information can be used by the medial office;

(2) To ensure that medical office personnel comply with HIPAA, by adopting and implementing privacy procedures for its medical practice, and training employees so that they understand the HIPAA procedures;

(3) To designate an individual to be responsible for seeing that the privacy procedures are followed; and

(4) To secure patient records that contains individually identifiable health information so that they are not readily available to those who do not have a need to have access to them.

The HIPAA privacy rules provide patients with more control over their health information. Patient confidence in the integrity of the health care system is essential in order to encourage patients to allow their health information to be released, without fear that the information will be misused.

Your protected health information may be used to disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this notice of our privacy practices. This notice will be in effect for one year from the signing date unless specifically revoked in writing.

Patient/Guardian Signature: _____ **(18 and over patient signs)**

Patient Name: _____

Date: _____

Post Office Box 1529, 905 East D Street Deer Park, WA 99006 Phone: 509-276-5005 Fax: 509-276-7785

CONSENT AGREEMENT
FOR PROVISION OF CHRONIC CARE MANAGEMENT

By signing this Agreement, you consent to Deer Park Family Care Clinic,(referred to as "Provider"), providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you if you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline. CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.

When providing CCM Services, the Provider will:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

Patients Acknowledgment and Authorization.

By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Patient Rights.

You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month. You may revoke this agreement verbally by calling 509 276 5005 or in writing. Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Patient Signature:

_____

Patient Name: Date: Acct. Number: