

2100 116th Ave NE
 Bellevue, WA 98004
 425-467-1314
 info@eriksuh.com

REGISTRATION FORM

(Please Print)

Today's date:		Email:		PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age: /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Primary phone no.: Home -Cell? ()		
P.O. box:		City:		State:	ZIP Code:		
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:		Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Primary insurance name:						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY					
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone no.: ()	Cell phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/provider. I understand that I am financially responsible for any balance. I also authorize S&L Healthcare, PLLC and its clinics or insurance company to release any information required to process my claims.					
Patient/Guardian signature				Date	

eastside

primary care & wellness

2100 116th Ave NE Bellevue, WA 98004
 Tel 425-467-1314 Fax 425-458-3102 ~ info@eriksuhmd.com

Original Date:

Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other:			
Race:		Ethnicity:	Preferred Language:
Occupation:			
Previous or referring doctor:			Date of last physical exam:
PERSONAL HEALTH HISTORY			
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia	
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox	
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>	
List any medical problems that other doctors have diagnosed:			
Surgeries			
Year	Reason	Hospital	
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers			
Name the Drug	Strength	Frequency Taken	
Allergies to medications			
Name the Drug	Reaction You Had		

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Never
	<input type="checkbox"/> Cigarettes - pks./day:	<input type="checkbox"/> # of years:	<input type="checkbox"/> Or year quit:	
Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind?			

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	
	<input type="checkbox"/> M	
	<input type="checkbox"/> F	

WOMEN ONLY

Age at onset of menstruation:	Date of last menstruation:	Period every _____ days
Number of pregnancies	Number of live births	
Heavy periods, irregularity, spotting, pain, or discharge?		
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have or had any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin:	<input type="checkbox"/> Chest/Heart:	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck:	<input type="checkbox"/> Back:	<input type="checkbox"/> Weight:
<input type="checkbox"/> Ears:	<input type="checkbox"/> Intestinal:	<input type="checkbox"/> Energy level:
<input type="checkbox"/> Nose:	<input type="checkbox"/> Bladder:	<input type="checkbox"/> Ability to sleep:
<input type="checkbox"/> Throat:	<input type="checkbox"/> Bowel:	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs:	<input type="checkbox"/> Circulation:	



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Patient Name: _____ Date: _____

(THE ASSIGNMENT AND CONSENT WILL BE SIGNED AT THE FIRST OFFICE VISIT)
ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, have insurance coverage with _____
And assign directly to Eastside Primary Care and Wellness, Erik Suh MD. PS. All medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Eastside Primary Care and Wellness, Erik Suh MD. PS. to release all information necessary, to secure the payment of benefits. I give permission to Eastside Primary Care and Wellness, Erik Suh MD. PS. to release information to my other health care providers. I authorize the use of this signature on all my insurance submissions.

X _____ Date: _____

Signature of insured/Guardian

CONSENT TO TREATMENT

It is our philosophy that patients should have full disclosure when receiving any type of health care. We therefore ask that you read and sign the following consent. We also fee that any individual should request the same full disclosure from any other health care provider and their proposed treatment plan. Educated choices are the only choices.

I understand that as a patient of Eastside Primary Care and Wellness, Erik Suh MD. PS., I will receive an initial evaluation, and thorough discussion of treatment options. The goal of the initial evaluation process is to determine the best course of treatment for me. I understand that typically treatment is provided over the course of several weeks to months.

I understand that all information shared with the healthcare providers is confidential and that no information will be released without my consent. During the course of treatment, it may be necessary for my providers to communicate with other healthcare practitioners. I understand that consent to release information is given through written authorization. Verbal consent for release of limited and essential information may be necessary in special circumstances.

I understand that while treatment may provide significant benefits, it may also pose risks. Short of overt negligence, I agree to hold the healthcare providers of Eastside Primary Care and Wellness, Erik Suh MD. PS. harmless in case of undesirable effects of undertaking or discontinuing treatment. I also understand that I may stop treatment at any time.

Please note: If applicable, co pays are due at each visit. I also understand that unless other arrangements have been made ahead of time, payment in full is due at the end of service each day.

It is your right to have a chaperon in the room during your exam. We will provide someone upon request.

If I have any questions regarding this consent form or about the services offered, I am encouraged to discuss them with the treating healthcare provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by the individual healthcare providers. I understand that I have the right to suspend any treatment at any time but that if this suspension of treatment is against medical advice that the consequences of my decision are my own responsibility.

X _____ Date: _____

Signature of insured/Guardian

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ DOB: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** your name

Please **sign** your name

Legal Representative

Description of Authority

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation Home Phone Confirmation Work Phone Confirmation Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

Signature of Privacy Officer



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OFFICE POLICIES AND PROCEDURES

Welcome to our practice. Our goal is to provide the best care possible to you and your family. To help answer questions you may have, we have outlined our clinic policies below. Please feel free to discuss these with us at any time if you have additional questions.

INSURANCE

As a courtesy to our patients, all claims will be submitted first to the insurance provided at the time of service. We are contracted with the following major insurance companies: Premera, Regence, Medicare, Labor and Industries, First Choice, United Health Care, Unicare and many others. Please ask at the front desk for other insurance we might bill.

We would like our patient to be aware that we no longer bill secondary insurance unless you are Medicare primary. You are responsible for any balance and may choose to bill your secondary insurance.

CREDIT POLICY

If you have no insurance, you will be asked to pay at the time of service unless arrangements have been made in advance with the Patient Account Manager.

If your insurance company requires a co-pay, it must be paid at the time of service. Please do not ask us to bill you for this amount.

Payment of private balances must be made within 30 days of receipt of monthly statements. We understand that financial problems do arise from time to time. Please let us know if you need to arrange a payment plan. We ask that you notify us while your charges are current.

A rebilling fee of \$5.00 per month will be added to accounts with an outstanding balance over 90 days after insurance processing. Delinquent accounts may be turned over to a collection agency.

If a check or bankcard payment is dishonored by your bank for any reason, an additional \$40.00 handling fee will be assessed to your account.

For our Cosmetic Procedures Financing is available for those who qualify through Care Credit. Plans and Interest rates vary. If this is something that you are interested in you may discuss this with our Patient Account Manager.

FAILURE TO KEEP APPOINTMENT

If you fail to keep two consecutive, scheduled appointments without 24-hour notification, a "no-show" charge of \$50.00 may be applied to your account. This charge will not be billed to insurance.

MEDICATION REFILL POLICY

All medication refills must be requested through your pharmacy, with the exception of prescription medications that require a written prescription from the provider. Please allow 24-48 hours for refills on all medications. Weekends and holidays do not count in the 24-48 hours waiting time. Our office does not refill any medication over the weekend or after hours. If you know that you are going to need a medication refilled over the weekend you must call your pharmacy on or before Wednesday.

All narcotic medication refill appointments require a urine analysis to determine appropriate medication monitoring before any refill is given to patients. Failures to provide a urine specimen sample for testing will possibly result in cancellation of your appointment or denial of your medication refill request. It is your right to petition this part of the assessment if you feel necessary, our office staff will gladly explain the procedures and protocol for your specific appointment situation.

PATIENT RESPONSIBILITIES

You are responsible for being considerate of other patients/visitors in our office, and respecting the clinic property.

You should respect our clinic staff. The medical staff deserves your respect and courtesy: treat them the way you would like to be treated by them!

Sincerely,

Eastside Primary Care and Wellness Staff

Print Patient Name

Patient Signature

Date

eastside

primary care & wellness

E-Mail Correspondence Consent form

We would like to send you email updates and flyers to inform you of our special events and services. We assure you that your email will not be distributed or shared with other contacts.

Email/or Mailing Address

Patient Name: _____

Patient Signature: _____

Date: _____