Eastside Primary Care & Wellness **Erik H. Suh, MD, PS.**

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: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ❑ M ❑ 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): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ 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? ❑ Yes ❑ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ 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: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ 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@erlksuhmd.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.):	☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other:		
Race:	Ethnicity:	Preferred Language:
Occupation:		
Previous or referring doctor:		Date of last physical exam:

PERSONAL HEALTH HISTORY

Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

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?	☐ Yes	☐ No	
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?	☐ Yes	☐ No	☐ Never
	☐ Cigarettes – pks./day:	☐ # of years:	☐ Or year quit:	
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No	
	If yes, what kind?			

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS
Father		
Mother		
Sibling	M F	
	M F	
	M F	
	M 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?			☐ Yes	☐ No
Any problems with control of urination?			☐ Yes	☐ No
Any hot flashes or sweating at night?			☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?			☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?			☐ Yes	☐ No
Date of last pap and rectal exam?				

MEN ONLY

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

OTHER PROBLEMS

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

☐ Skin:	☐ Chest/Heart:	☐ Recent changes in:
☐ Head/Neck:	☐ Back:	☐ Weight:
☐ Ears:	☐ Intestinal:	☐ Energy level:
☐ Nose:	☐ Bladder:	☐ Ability to sleep:
☐ Throat:	☐ Bowel:	☐ Other pain/discomfort:

Eastside
primary care & wellness

2100 116th Ave NE
Bellevue, WA 98004

P: 425-647-1314
F: 425-458-3102

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 feel 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 / FACILITYS 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 Surname ☐ 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 _____
☐ Email (appointment reminders only) _____
☐ **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

eastside
primary care & wellness

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

Failure to keep scheduled appointments without providing 24-hour notification, a "no –show", "last min cancellation" or last min reschedule will result in a fee of $50.00 which will be applied to your account. This fee must be paid prior to scheduling your next appointment. 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 RESPONSIBILTIES

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**

Authorization for Eastside Primary Care and Wellness

Erik H. Suh, MD, PS.

TO

Obtain my Health Care Information

2100 116th AVE. NE Bellevue, WA 98004 Phone (425)-467-1314 Fax (425)-458-3102

Patient Name_____ Date of Birth _____

Previous Name_____SSN_____-_____-_____

Address: _____City_____State ___Zip: _____ Phone ____-____-_____

I. My Authorization

You may use or disclose the following health care information (check all that apply)

___ All health care information in my medical record

___ Health care information in my medical record relation to the following treatment or conditions_____

___ Health care information in my medical record for the date(s) of_____

___ Other (e.g., X-rays, bills) specify_____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply)

___ HIV ___ Sexually transmitted diseases

___ Psychiatric disorders/mental health ___ Drug and/or alcohol use or abuse

You may obtain this health care information from:

Name or organization: _____

Address_____City_____State_____Zip____

Reason(s) for this authorization (check all that apply)

____ Collaborative care with other health care provider(s)

____ Change of health care providers

____ Legal purposes (i.e.: motor vehicle accident)

____ Third party billing

____ Other (please explain)

This authorization ends: _____

II. My Rights

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Eastside Primary Care Erik H. Suh, MD, PS. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

1. Fill out a revocation form. (available from Eastside Primary Care and wellness, Erik H. Suh, MD , PS. or
2. Write a letter to Eastside Primary Care and wellness, Erik H. Suh, MD, PS.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____

Patient or legally authorized individuals signature Date Time HIPPA-EPC 2016

East
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: _____

2100 116th Ave Ne
Bellevue, WA 98004
Tel: (425) 467-1314
Fax: (425) 458-3102
Email: info@eriksuh.com
Web: www.eriksuh.com

Erik H. Suh, MD, PS.