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.):* ☐ 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:

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**

Eastside Primary Care & Wellness

2100 116th Ave NE | Bellevue, WA 98004

Tel 425-467-1314 Fax 425-458-3102- info@eriksuh.com

First Name	Middle Name / MI	Last Name	Date of Birth

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. **Please review it carefully.**

Protected Health Information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with Eastside Primary Care & Wellness. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Eastside Primary Care & Wellness is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control *your* PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Health Information Rights

Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making any decision about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our practice manager. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored offsite, we are allowed up to 60 days to respond but must inform you of this delay.

Request Amendment: You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and the reasoning that supports your request. We will respond in writing within 60 days of your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if:

- The information was not created by us, or the person who created it is no longer available to make the amendment;
- The information is not part of the record which you are permitted to inspect and copy:
- The information is not part of the designated record set kept by this practice; or if it is the opinion of the health care provider that the information is accurate and complete.

We will respond within 60 days, in writing, explaining of the request was accepted or denied.

Request an alternative means of confidential communication: You have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, {using a form provided by our practice}, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

Request a restriction of your PHI: This means you have the right to ask us, in writing, not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction

An accounting of Disclosure: You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates greater than six years (our legal obligation to retain information).

Your first request for a list or d isclosures within a 12month period will be free. If you request an additional list within 12months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will accommodate all reasonable requests.

A Paper Copy Of This Notice: You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit by calling and asking us to mail you a copy.

File a Complaint*:* If you believe we have violated your medical information privacy rights, you have the right to file a complaint with us, or directly to the Secretary of Health and Human services.

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

Authorize other use and disclosure: You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice, has taken an action in reliance on the use or disclosure indicated in the authorization.

We may contact you to provide information about health related benefits and services offered by our office, for fundraising activities, share information in a disaster relief situation , include your information in a hospital directory, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Ways in which we may use and Disclose Your Protected Health Information:

THE FOLLOWING PARAGRAPHS DESCRIBE DIFFERENT WAYS THAT WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION. WE HAVE PROVIDED AN EXAMPLE FOR EACH CATEGORY, BUT THESE EXAMPLES ARE NOT MEANT TO BE EXHAUSTIVE. WE ASSURE YOU THAT ALL OF THE WAYS WE ARE PERMITTED TO USE AND DISCLOSE YOUR HEALTH INFORMATION FALL WITHIN ONE OF THESE CATEGORIES.

Treatment: We will use and disclose your protected health information to provide. coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician whom we have requested to be involved in your care. For example we should disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Health care Operations: We will use and disclose your protected health information to support the business activities of our practice. For example - we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third-party business associates who perform billing, consulting. or transcription services for our practice.

Payment: We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example we may include information with a bill to a third party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Other Ways We May Use and Disclose Your Protected Health Information

PUBLIC HEALTH: **WE WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN CERTAIN SITUATIONS TO HELP WITH PUBLIC HEALTH AND SAFETY ISSUES. SOME OF THE SITUATIONS INCLUDE:**

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Research: We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As required By Law: We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

Other Permitted and Required Uses and Disclosures: We are also permitted to use or disclose your PHI without your written authorization for the following purposes:

- **TO COMPLY WITH FOOD AND DRUG ADMINISTRATION REQUIREMENTS**
- Legal proceedings
- Coroners
- Funeral directors
- Organ donation
- Criminal activity
- Military activity
- National security
- Worker's compensation
- When an inmate is in a correctional facility
- If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

By signing this form you acknowledge you were advised of the HIPAA Notice of Privacy Practices. Our HIPAA Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. You may request a copy of the Notice of Privacy.

Date

_____

Signature of Responsible Party

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. ❑ Mrs.	❑ Miss ❑ 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*

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 2019

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: _____

Authorization to Discuss Medical Information

I, patient named below, hereby authorize Eastside Primary Care & Wellness to use or disclose the specific information described below, only for the purposes and parties also described below.

Is it ok to leave messages at your home?

Yes No

Is it ok to leave messages on your cell?

Yes No

FIRST NAME

MIDDLE NAME / ML

LAST NAME

DATE OF BIRTH

Information to be given to:

Name

RELATIONSHIP

PHONE

Description of the specific information to be discussed

- Appointment Date/Times
- Lab Tests, Imaging/X-ray Results, Medications/Refills,
- Summary of Medical Record, Care Plan and Diagnosis
- Billing
- Other

Specify Other

Indicate Confidential Information

- Mental Health
- HIV/STI information
- Alcohol/Drug Information

Information to be given to:

Name

Relationship

Phone

Description of the specific information to be discussed

- Appointment Date/Times
- Lab Tests, Imaging/X-ray Results, Medications/Refills,
- Summary of Medical Record, Care Plan and Diagnosis
- Billing
- Other

SPECIFY OTHER

Indicate confidential information

- Mental Health
- HIV/STI information
- Alcohol/Drug Information

Information to be given to:

Name

Relationship
Specify Other

Phone
Indicate Confidential Information

Description of the specific information to be discussed

- Appointment Datemmes
- Lab Tests, Imaging/X-ray Results, Medications/Refills,
- Summary of Medical Record , Care Plan and Diagnosis
- Billing
- Other

- Mental Health
- HIV/STI information
- Alcohol/Drug Information

Information to be given to:

Name

Relationship

Phone

Description of the specific information to be discussed

Specify Other

Indicate Confidential Information

- Appointment Datemmes
- Lab Tests, Imaging/X-ray Results, Medications/Refills,
- Summary of Medical Record, Care Plan and Diagnosis
- Billing
- Other

- Mental Health
- HIV/STI information
- Alcohol/Drug Information

This authorization shall remain In effect from the date signed below until:

Expiration date or event

- (specify expiration date or event)
- NO EXPIRATION DATE

I **understand that:**

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Administrator .
- This authorization is giving Health Center Name the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Date

Signature:

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