COMPASSION FAMILY MEDICINE

Patient Registration Form

Date_____

Patient Name_____ DOB_____ Gender: M F

Mailing Address_____ City_____ State_____

Zip_____ Home Phone_____ Cell Phone_____ Preferred Contact Method_____

Social Security#_____ E-Mail Address_____

O I consent to receive electronic billing at the E-mail address listed above, and I consent to allow CFM to leave me a message on my electronic device: not limited to message phone, cell phone, E-mail, text, etc.

Emergency Contact_____ Relationship_____ Phone #_____

INSURANCE INFORMATION

INSURANCE CARRIER_____PLAN_____
NAME OF SUBSCRIBER OF THE PLAN_____SUBSCRIBER DOB_____
A COPY OF THE FRONT AND BACK OF YOUR CURRENT INSURANCE CARD IS REQUIRED BEFORE WE CAN ACCEPT THIS APPLICATION FOR CARE.

FINANCIAL/APPOINTMENT POLICY

1. Copayment is required at the time of service.
2. Insurance is accepted and filed as a courtesy; however, the patient holds ultimate responsibility for co-pays, co-insurance, and any service not covered by their insurance plan.
3. Payment is full is required for Private Pay visits.
4. A fee of $35.00 will be charged on all returned checks.
5. Delinquent accounts of more than 90 days will be sent in collections. The responsible party will be responsible for all agency fees, court costs, and attorney's fees in addition the outstanding balance due Compassion Family Medicine for services rendered.
6. We allow 2 Missed/Late Cancel (less than 24 hour notice or 10 minutes late) before you are unable to schedule with our clinic for established patients.
7. If a New Patient appointment is missed, cancelled less than 24 hours in advance or more than 10 minutes late it will be rescheduled.

I HAVE READ, UNDERSTAND AND ACCEPT COMPASSION FAMILY MEDICINE'S FINANCIAL POLICY

Patient or Responible Party's Signature_____

Patient or Responible Party's Printed Name_____

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

COMPASSION FAMILY MEDICINE

Patient Registration Form

The reason you are requesting an appointment today?

_____

_____

What is your current Age?_____Weight? _____ Height? _____

Are you currently in pain? YES NO How long have you been experiencing pain? _____

Please rate your pain on a 1-10 scale (1 lowest & 10 highest): 1 2 3 4 5 6 7 8 9 10

Where is your pain located_____

Are you currently being treated for chronic pain?_____

Please circle from the following that best describe the pain.

Aching	Burning	Cramping	Pulling
Radiating	Stabbing	Throbbing	Tightness
Dull	Tender	Sharp	Other_____

Circle any symptom you are currently experiencing, have recently experienced, or is a chronic condition for you.

Constitutional

Chills	Fever	Sweats
Weight Gain	Sleep Disturbances	
Weight Loss	Fatigue	

Eyes

Redness	Cataracts
Glaucoma	Vision Changes
Blurred Vision	Double Vision

Ears/Nose/Throat

Sore Throat	Earache Left / Right
Dizziness	Hearing Loss Left / Right
Nasal Congestion	Nosebleeds

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

COMPASSION FAMILY MEDICINE

Patient Registration Form

Cardiovascular

Chest pain

Palpitations

Chest tightness

Heart murmur

Leg pain (sit/walk)

Lower Extremity Swelling

Respiratory

Cough

Wheezing

Shortness of Breath

Pain with Breathing

Skin

Mass Mole change Location_____

Rash

Bump Wart Location_____

Pain

Back Pain Location _____ Chronic/Acute

Joint Pain Location_____ Chronic/Acute

Extremity Pain Location _____ Chronic/Acute

Neuro/Psych

Dizziness	Fainting	Headache	Migraines
Memory Loss	Numbness	Seizure	Tremor
Vertigo	Weakness	Nervous	Confused

Depression Mild / Moderate / Major / Seasonal / Chronic

Anxiety Mild / Moderate / Severe / Panic / Chronic

PLEASE US THIS SPACE FOR ADDITIONAL INFORMATION REGARDING YOUR HEALTH AND CONCERNS TODAY

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

COMPASSION FAMILY MEDICINE

Patient Registration Form

List all medications and dosage that you are currently prescribed. You are also required to bring all medications, including vitamins, on your first visit to our clinic.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History

Do you smoke? NEVER OCCASIONALLY REGULARLY PAST

How many packs per day? _____

Do you consume alcohol NEVER OCCASIONALLY REGULARLY PAST

How much per day? _____

Do you use other substances? NEVER OCCASIONALLY REGULARLY PAST

What, how much, & how often do you use:

WHAT	HOW MUCH	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy Name and Location_____

Allergies—Please list all allergies to food, medicines, animals, environment, seasonal etc.

Allergy	Reaction
_____	_____
_____	_____
_____	_____

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

COMPASSION FAMILY MEDICINE

Patient Registration Form

Past Surgeries & Age at Time of Surgery:

_____ _____ _____

_____ _____ _____

Family History: Please List Family Member and Serious Medical Issues:

Mother_____

Father_____

Grandparents_____

Siblings_____

Health Responsibilities: As a patient, you must give the provider your accurate and complete medical history. You need to notify the provider of any pre-existing conditions. You need to inform the provider of any changes or symptoms. You need to follow your provider's treatment plan. If you do not understand the diagnosis, treatment, or prognosis, please ask questions.

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

Confidential Communications Form (HIPAA Form)

To protect your privacy, we need your written permission to give personal health information to anyone besides you. However, it should be noted our current notice of privacy practices allow us to call you with a courtesy reminder regarding upcoming appointments. This PHI can be released in any of the following forms: hard copies, verbally, or electronically. This information can include several things including but not limited to lab or imaging results, orders, referrals, historical medical records, medications lists, vaccination history, encounters and procedures, and administrative documents.

Please read the following and tell us whether we can leave information regarding your medical information and with whom we may leave it with

---

Please choose one of the following:

- O **I DO CONSENT** to release personal health information as follows:

I, _____, give Compassion Family Medicine and their staff my permission to release information regarding my medical care with the following options: (Initial each one that applies.) This will remain in effect until you rescind it in writing.

- Leave a detailed message on my home phone_____ or cell phone_____. Initials_____
- My spouse (name)_____ Initials_____
- Other (name)_____ Initials_____
-

Signature_____ Date_____

Printed Name of Signer_____

- O **REVOCATION** of prior consent

I, _____, wish to rescind or stop previous authorizations.

Signature_____ Date_____

Printed Name of Signer_____

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

COMPASSION FAMILY MEDICINE

Patient Registration Form

Code of Conduct for Patients/Family/Visitors

To provide a safe and healthy environment for staff, visitors, patients and their families, Compassion Family Medicine expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or our unhappy with the service received in our office, please contact our practice manager before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the doctor at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the doctor can give all patients the time and quality of care they deserve.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing it away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

• Possessing firearms or any weapon

• Intimidating or harassing staff or other patients

• Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication

• Physically assaulting or threatening to inflict bodily harm

• Making verbal threats to harm another individual or destroy property

• Damaging business equipment or property

• Making menacing or derogatory gestures

• Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and discharge from the practice.

Patient/Guardian Signature_____ Date_____

Printed Name of Signer_____

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Compassion Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand revisions of Notice of Privacy Practices can be made at any time. A revised Notice of Privacy Practices may be obtained by make a request to the office staff.

With this consent, Compassion Family Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Compassion Family Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements.

With this consent, I agree to mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that PRACTICE restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Compassion Family Medicine to use and disclose my PHI to carry out treatment, payment, and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Compassion Family Medicine may decline to provide treatment.

Patient or Guardian Signature_____ Relationship_____

Print name of Signer_____Date_____

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388

COMPASSION FAMILY MEDICINE

Patient Registration Form

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____Date of Birth: _____Previous Name: _____

I request and authorize_____
to release health care information of the patient named above to:

Name: Compassion Family Medicine

ADDRESS: 3810 Kern Rd "B", Yakima, WA 98902 FAX: 844-315-7388 PHONE: 509-228-7237

EMAIL: CFM@compassionfamilymedicine.com

This request and authorization apply to:

- O Healthcare information relating to the following treatment, condition, or dates:
- O Healthcare information for the last 3 years from today
- O All health care information
- O Other:

  _____

  Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- O **Yes** or
- O **No**:

  I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

  Yes or

- O **No**:

  I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient/Guardian Signature: _____ Date_____
Printed Name of Signer_____

THIS AUTHORIZATION EXPIRES A YEAR AFTER IT IS SIGNED

3810 KERN WAY SUITE B YAKIMA WA 98902 PHONE 509.228.7237 FAX 844.315.7388