Dericks Family Medicine
1409 NW 85th Street
Seattle, WA 98117

Phone: (970) 331-2583
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drbeebedericks@gmail.com
www.dericksfamilymedicine.com

PATIENT REGISTRATION FORM
(confidential patient information)

Name: _____ DOB: ____/____/____ Gender:_____

Nickname or Preferred Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Email: _____ Cell/Home #: _____

Work Phone #: _____ What phone do you prefer to be reached at? _____

Do you authorize voicemails/text messages at this number? Y N Who referred you? _____

Marital Status (circle): Married Single Partner Widowed Dependent Other: _____

Do you have children? Y N If so, how many dependents? ____

Occupation: _____ Employer: _____

FAMILY

Spouse/ Partner Name: _____ Home/Cell Phone #: _____

Occupation: _____ Spouse/Partner Employer: _____

Work Phone #: _____ Email: _____

EMEGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Home/Cell #: _____ Work Phone: _____

HEALTH CARE PROVIDERS

Family Physician: _____ Clinic Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Who is your referring physician? _____

HEALTH AND WELLNESS INFORMATION

MEDICAL HISTORY

Date of most recent physical exam ____/____/____ Physician: _____

History of Serious Illness(es) Please list, include Date: _____

_____

What surgeries/ trauma have you experienced? When did they occur? _____

_____

Allergies/ Food Sensitivies? Please list _____

PRESENT ILLNESS

What is your chief complaint? _____

When did this condition begin? _____

Has a diagnosis already been made by a health care practitioner? If so, what was the diagnosis, and who made it?

_____

What treatments have you already received? _____

Have you had any imaging done? Y N What forms? _____

Please rate your discomfort today: (10=most) 1 2 3 4 5 6 7 8 9 10

Please describe your discomfort: _____

Does heat or cold alleviate the pain? Y N Does pressure alleviate the pain? Y N

Does weather affect your discomfort? Please describe _____

WOMEN'S HEALTH

Date of Last Menstrual Cycle: ____/____/____ Age of first menses _____ Date of last pap _____

# of days between menses _____ Duration of menses _____ Age of menopause _____

Are you currently pregnant? Y N If so, How many weeks? _____ # of Live Births: _____

Miscarriages? If so, how many? _____ # of abortions _____ Pelvic Surgeries: _____

Do you plan on becoming pregnant? Y N

Have you been diagnosed with a gynecological condition? Y N Please list: _____

_____

FAMILY HEALTH HISTORY

Please list significant diseases and health conditions of family members: _____

_____

_____

MEDICATIONS

Allergies to Medications/Supplements: _____

_____

Please list all medications, including prescriptions, over-the-counter, and herbal or vitamin supplements

Meds/Supplement (please include dosage and brand)	Start Date and Prescribing Provider

MEDICAL CONDITIONS

Please indicate if you have EVER had any of the following:

- o Asthma
- o Seasonal Allergies
- o Pneumonia
- o Respiratory Infection
- o Emphysema
- o Tuberculosis
- o Whooping Cough
- o Hoarseness
- o Difficulty Swallowing
- o Teeth Grinding

- o Thyroid Disorder
- o Congenital Abnormalities
- o Diabetes Mellitus
- o Diabetes Insipidus
- o Epstein Barr Virus (EBV)
- o Cancer (Specify) _____

- o Fibromyalgia
- o Peripheral Neuropathy
- o Rheumatoid Arthritis
- o Osteoarthritis
- o Skin Rashes or Diseases

_____

- o Obvious change in Wart/ Mole
- o Shingles

- o Epilepsy or Seizure Disorder
- o Heart Disease
- o High Blood Pressure
- o Low Blood Pressure
- o Fainting/Dizziness
- o Tinnitus
- o Rheumatic Fever
- o Stroke

- o Heart Attack
- o Cardiac Pacemaker and/or Defibrillator
- o Blood clots
- o Fainting
- o Bleed or bruise easily

- o Kidney Disease
- o Kidney Stones
- o Urinary Bladder Problems/Infections
- o Frequent or Painful Urination
- o Prostate Problems
- o Erectile Dysfunction

- o Peptic Ulcer
- o Gastric Ulcer
- o Pancreatitis
- o Acid Reflux
- o Colitis
- o Crohn's Disease
- o Irritable Bowel Syndrome
- o Gallstones
- o Gallbladder Disease
- o Hernia
- o Hemorrhoids
- o Change in Bowel or Bladder Habits
- o Blood in Stool
- o Anorexia nervosa
- o Bulimia
- o Food allergies /sensitivity _____

- o Anemia or Other Blood Disorder
- o Bleeding Disorder
- o Unusual Bleeding or Discharge

- o Jaundice

- o Disorder of the Genitalia
- o Sexually Transmitted Infection
- o Hepatitis A / B / C
- o History of Sexually Transmitted Disease
- o HIV or AIDS

- o Gynecological Disorder (PCOS, fibroids, etc.)

_____

- o PMS
- o Irregular periods
- o Painful periods
- o Infertility
- o Breast lumps

- o Vision Changes
- o Disorder of the Eye

_____

- o Surgical Implants
- o Unexplained Weight Loss/Gain

- o Depression
- o Anxiety
- o Memory Loss
- o Poor Sleep
- o Alcohol/Drug Abuse
- o Other _____

_____

SOCIAL HISTORY

Do you exercise? Y N How often? _____ What activities? _____

What's your stress level? (10=most) 1 2 3 4 5 6 7 8 9 10

What triggers your stress? _____

How is your energy level? (10=most) 1 2 3 4 5 6 7 8 9 10

Do you struggle with anxiety or depression? Y N If so, what? _____

Do you have sleeping difficulties? Y N

Which of the following?

- o Staying Asleep
- o Falling Asleep
- o Waking Refreshed
- o Racing Mind

- o Pain
- o Frequent Urination
- o Hot Flashes
- o Other _____

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HIPAA Notice of Privacy Practices

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Your Rights

Get an electronic or paper copy of your medical record:

• You can ask to see or get an electronic or paper copy of your medical record and other health information we have to ask about you. Ask us how to do this.
• We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record:

• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
• We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications:

• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
• We will say "yes" to all reasonable requests.

Ask us to limit what we use or share:

• You can ask us NOT to use or share certain health information for treatment, payment, or our operations.
• We are not required to agree to your request, and we may say "no" if it would affect your care.
• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
• We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information:

• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
• We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice:

• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you:

• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
• We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated:

• You can complain if you feel we have violated your rights by contacting us using the information provided on page 1.

• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W.,Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
• We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we use your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and the choice to tell us to:
• Share information with your family, close friends, or others involved in your care.
• Share information in a disaster relief situation.
• Include your information in a hospital directory.
• Contact you for fundraising efforts.
• *If you are not able to tell us your preferences, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases, we never share your information unless you give us written permission:
• Marketing purposes
• Sale of your information
• Most sharing of psychotherapy and medical chart notes

In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures
We typically use or share your health information in the following ways:

To treat you:
• We can use your health information and share it with other professionals who are treating you. *Example: a doctor treating you for an injury asks another doctor about your overall health condition.*

To run our organization:
• We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: we use health information about you to manage your treatment and services.

To bill for services:
• We can use and share your health information to bill and get payment from health plans or other entities.
Example: we give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
• We can share health information about you for certain situations such as:
• 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

Do research:
• We can use or share your information for health research.

Comply with the law:
• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests:
• We can use or share health information about you:
• For worker's compensation claims
• For law enforcement purposes or with a law enforcement official
• With health oversight agencies for activities authorized by law
• For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions:
• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Additional information pertaining to Dericks Family Medicine:
• We do not create psychotherapy notes at this practice.
• Except in the rare cases stated above, we do not disclose the identity of any person who has investigated, considered, or requested a test or treatment for a sexually transmitted disease without written permission.
• We will never share any substance abuse treatment records without your written permission.

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 if 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.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Effective Date of Notice: August 1, 2016
This Notice of Privacy Practices applies to the following organizations: Dericks Family Medicine, PLLC

For questions or concerns regarding any part of this Notice of Privacy Practices, please contact us at the phone number, email, and/or address on page 1.

Dericks Family Medicine

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I, _____, acknowledge that I have been provided with the Notice of Privacy Practices for Dericks Family Medicine, which outlines how my PHI ("protected health information") is used at this clinic. I understand that a copy of the Notice of Privacy Practices is always available to me online, and that I may receive a printed copy if I request one.

I understand that if I have any questions, concerns or complaints I may contact Dr. Beebe Dericks at (970) 331-2583.

I also understand that I am entitled to receive updates of the Dericks Family Medicine's Notice of Privacy Practices, should they occur.

_____ _____

Signature Printed Name

_____ _____

Date Relationship to Patient (if signed by someone other than the patient)

Office Use Only:

I attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but I was unable to because:

[ ] Patient refused to sign this written Acknowledgement

[ ] Other (specify): _____

Dericks Family Medicine
Clinic Policies and Procedures

Scheduling Policy
You may schedule an appointment with us at any time by calling our clinic directly. You are encouraged to make follow up visits at the end of your current appointment.

Cancellation Policy
When you schedule an appointment, we reserve that time for you. In addition, we set aside time prior to your appointment for review and research of information particular to your healthcare needs and goals. Because of this, **we require a minimum of 24 hours notice of cancellation** prior to your appointment time. 48 hours is recommended. Canceling less than 24 hours in advance of your appointment will incur a fee of 50% of the cost of your appointment, due immediately. We are unable to reserve any portion of this fee for participation in our donation program.

That said, we understand that emergencies happen. If something unexpected occurs that requires you to miss your appointment, please let us know as soon as possible.

No Shows
We reserve the right to charge a missed appointment fee for any appointment you miss with no notice. This fee is 75% of the cost of your appointment, due immediately. We are unable to reserve any portion of this fee for participation in our donation program. If you miss several appointments over a short period of time, we may decide to end your medical care with us. You will still be liable for any outstanding balance.

Cell Phones
We strive to maintain a relaxing and rejuvenating atmosphere for our clients. Please help us achieve this by silencing your cell phone in our offices.

Termination of Care
At any point we reserve the right to terminate our care of you. While this rarely occurs, we acknowledge that sometimes the particular doctor:client relationship may not be in the either party's best interest. Should we determine that termination of care is appropriate, you will be notified that this is the case; furthermore, we will offer three alternative practitioner referrals to you. At any point you reserve the right to terminate our care of you. Should you decide that this is the best course of action for you, any outstanding fees owed our clinic will be immediately due.

Financial Policy
Payment is due in full at time of services rendered. Accepted payment forms include cash, check, debit, Visa, Mastercard, American Express, and Discover credit cards. A fee of $25 is incurred for all returned payments due to insufficient funds. We do not accept insurance; however, if your insurance covers the services rendered at our clinic, we will provide you with the necessary forms to submit to your insurance company for reimbursement. The reason we do not bill insurance is to provide us with adequate time to assess and treat you. We recognize the difficulty of working within the time requirements imposed by some insurance plans, and to continue to provide you with the best service possible, we have chosen to work outside of that system.

All dispensary items must be paid in full at time of purchase. Unopened dispensary items may be returned within 30 days of purchase; receipt is required for refunds.

Lab testing must be paid for in full at time of ordering the test.

Overdue accounts will accrue 1.5% interest after 60 days, and may be forwarded to a collection agency.

By signing below, I acknowledge that I understand and agree to the Policies and Procedures of this clinic, including the Financial Policies. I agree to pay in full at time of appointment.

_____

Signature

_____

Printed Name

_____

Date signed

CONSENT FOR TREATMENT

Dericks Family Medicine is an integrative medical clinic that includes a number of medical treatment modalities. Due to the diversity of modalities offered at Dericks Family Medicine, your treatment may include any or all of the following general modalities: East Asian medicine (Acupuncture), Naturopathic Medicine, Physical Medicine, Homeopathy, Psychological Counseling and Nutritional Counseling. All of our physicians and East Asian medical practitioners are licensed in the State of Washington and have completed graduate level training and national board certification.

Physicians and practitioners at Dericks Family Medicine may perform any of the following specific procedures as necessary to facilitate assessment of condition, diagnosis, treatment, or otherwise address health concerns:

1. **General Diagnostic Procedures:** including but not limited to venipuncture, pap smears, radiography, and blood and urine laboratory analysis, general physical exams, neurological and musculoskeletal assessments
2. **Psychological Counseling;** Lifestyle Counseling; Exercise Prescriptions
3. **Herbs/Natural Medicines**: prescribing various therapeutic substance including plant, mineral and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly diluted quantities of naturally occurring substances, may also be used.
4. **Dietary Advice and Therapeutic Nutrition**: includes the use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin and homeopathic injections.
5. **Soft Tissue and Osseous Manipulation:** includes the use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, high-velocity low-amplitude adjustments, functional indirect manipulation, and craniosacral therapy.
6. **Electromagnetic and Thermal Therapies:** includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, microcurrent stimulation, diathermy and infrared, red light and ultraviolet therapies or moxa (warming or indirect burning of an acupuncture point and hydrotherapies)
7. **Acupuncture**: insertion of special sterilized needles or lancets at specific points on the body
8. **Topical Treatments and Prepping**: includes cupping – a technique using glass cups on the surface of the skin with usually a heat-created vacuum; and Gua Sha – rubbing on an area of the body with a blunt, round instrument.

Potential Risks: While not common, harm can occur from any therapy. Some examples can include but are not limited to: Pain, discomfort, blistering, discolorations, infection, or burns from topical procedures, heat or frictional therapies, electromagnetic and hydrotherapies; loss of consciousness or deep tissue injury from needle insertions or needle breakage; allergic reactions to prescribed herbs or supplements; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms. In addition, the patient must inform the practitioner if the patient has a severe bleeding disorder or pacemaker prior to treatment.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques (including labor stimulating acupuncture points) or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

By signing below, I, (or my authorized representative on my behalf) authorize Dericks Family Medicine and their staff to conduct any of the methods, procedures and therapeutic approaches listed above. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dericks Family Medicine or its practitioners and staff regarding cure or improvement of my condition. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I

understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

CONSENT FOR TREATMENT

Patient's Name (PRINT)	Guardian/Personal Representative's Name (PRINT)	Date
_____	_____	_____
Patient's Signature	**Guardian/Personal Representative's Signature**	**Date**
_____	_____	_____

Dericks Family Medicine

PATIENT CONSENT FOR E-MAIL COMMUNICATIONS

It is Dericks Family Medicine's understanding that you would like us to communicate with you via e-mail. In advance of sending you e-mails that may contain your protected health information, we want to advise you that there may be some level of risk that information in an unencrypted e-mail could be read by a third party. Upon your approval below, Dericks Family Medicine Clinic may send you e- mails, which may contain your protected health information, using unencrypted e-mail. Clinic hereby expressly disclaims any responsibility for any unauthorized access of your protected health information in e-mails that we send to you pursuant to this consent.

Alternatively, you may contact us through your Patient Portal.

If you have any questions about this form or about our communications with you about your protected health information, you may speak to Dr. Beebe Dericks at (970) 331-2583.

I, the undersigned, consent to e-mail communications with Clinic and its employees about my protected health information and I understand the risks associated with using unencrypted e-mail communications. I will inform Clinic in writing if I no longer wish to communicate with Clinic via e- mail.

_____

Name (printed)

_____

Signature

_____

Date