TouchStone HEALTH CLINIC

Where healing begins

2019 Patient Update Form

DEMOGRAPHICS

Patient Name: _____ Today's Date: _____

Guardian Name (if needed) _____ Patient Date of Birth: _____

1.) Has your contact information changed since you were last seen (check one)?
____ YES ___ NO - If Yes, please provide the following information:

Address: _____ City: _____

State: _____ Zip: _____ Email:_____ Phone: _____

I authorize Touchstone Health Clinic to leave health related information via the following options (Circle or Check)?: Phone – Cell Home Work Email or _____ DO NOT CONTACT

2.) Has your employer changed?
___ YES ___ NO ___ Other: _____

If Yes, please provide the following information: Name of Employer: _____

Address: _____

Phone Number: _____ Occupation: _____

Have you had a work related Injury? ___ YES ___ NO ___ Other: _____

If Yes, Date of Injury: _____

3.) Has your Emergency Contact changed? ___ YES ___ NO. If Yes, please provide the following information:

Name: _____ Relationship: _____

Phone: _____ Secondary Phone: _____

TouchStone
HEALTH CLINIC
Where healing begins

4.) Has your Primary Health Care Provider changed? ___ YES ___ NO. If Yes, please provide the following information: Name: _____ Clinic Name: _____

Address: _____ Phone: _____

5.) Do you or did you have a change to an Advance Directive? ___ YES ____ NO If Yes, when was it last reviewed? Date: _____

If you do not have one, would you like one? ____ YES ___ NO

6.) Has your Health Insurance Changed? ___ YES ___ NO If Yes, please provide the following information:

Name of Insurance Company: _____

Address (on back of card): _____

Phone Number (on back of card): _____ Group #:_____

Patient ID#: _____

Are you under a spouse's or parents health plan? ___ YES ___ NO If Yes, please provide the following information: Name of Subscriber: _____ Date of Birth: _____

7.) To better help you with financial services please provide the following additional information:

Has your Family Size Changed?: ___ YES ___ NO

If Yes, pleas provide number of family members in your household _____

Has your Total Household Income Changed?: ___ YES ___ NO

If Yes, please provide the total household income _____

TouchStone
HEALTH CLINIC
Where healing begins

LIFE CHANGES

8.) Since you last completed Touchstone Health Clinic paper work has any of the following occurred:

Married (circle): ___ YES ___ NO Divorced (circle): ___ YES ___ NO ___ Other: _____

Have you had children since you were last seen at Touchstone?: ___ YES ___ NO

Have there been any changes with your children you are concerned about?: ___ YES ___ NO ___ Other:

9.) Has there been a financial change you are concerned about (loss of job or stress of new job)?:
___ YES ___ NO ___ Other: _____

Has there been a change in the usage of drugs, alcohol or tobacco?: ___ YES ___ NO ___ Other: _____

Has there been a change in your personal safety?: ___ YES ___ NO ___ Other: _____

Has there been a change in your sexual history?: ___ YES ___ NO ___ Other: _____

Has there been a change in your daily activities, i.e. exercise routine?: ___ YES ___ NO ___ Other: _____

MEDICAL CHANGES

10.) Since your last visit, have you been admitted to the hospital?:
___ YES ___ NO ___ Other: _____

If Yes, where and when?: _____

11.) Since your last visit, have you had any medical tests?:
___ YES ____ NO ___ Other: _____

If Yes, please check any that apply:

____ Mammogram ____ Blood Work ____ Vision ____ MRI ____ Pap Smear ____ X-Rays _____ CT Scan

____ Colonoscopy _____ ECG/EKG ____ Other: _____

Where were the tests done?: _____

TouchStone
HEALTH CLINIC
Where healing begins

12.) Since your last visit, have you developed any new allergies or had a bad reaction to a medication, food or substance?:
____ YES ____ NO ____ Other: _____

If Yes, please describe: _____

13.) Since your last visit, have you seen a specialist (i.e. cardiologist, endocrinologist, gynecology, urologist)?:
____ YES ___ NO ___ Other:_____

If Yes, who was the specialist?: _____

14.) Since your last visit, have you had any vaccinations (shoots)?: ____ YES ____ NO

If Yes, which vaccines? ____ Flu ____ Tetanus ____ Pneumonia ____ Shingles

Other: _____

15.) Since your last visit, have you started taking any new medications?: ___ YES ___ NO

If Yes, please list all new medications you are taking:

_____

_____

16.) Since your last visit, have you started taking any new over-the-counter medications or herbal medications or supplements? ____ YES ____ NO

If Yes, please provide a list of all over-the-counter medications, herbal medications or supplements you are taking: _____

_____

PATIENT PORTAL

17.) For primary care patients Office Ally Patient Portal will soon be available to you. The Patient Portal is a secure online access to your medical records, and safe communication portal platform. Please indicate the following:

___ YES I would like to be set up on the Office Ally Patient Portal. If Yes, please provide the following:

Email: _____

___ NO I do not wish to be set up on the Office Ally Patient Portal.

TouchStone
HEALTH CLINIC
Where healing begins

Insurance Disclosure & Assignment of Benefits

Touchstone Health Clinic collects client credit card information in order to conveniently collect and/or bill co-pays, co-insurance, deductibles, missed appointment fees, and other outstanding fees. The most important thing is that you get the support and care you need and we at Touchstone want you to be reassured that we welcome you to continue to come to appointments, regardless of having an outstanding balance. Should finances be of concern, we respectfully request that you be put on a payment plan to help cover outstanding costs. Payment plans are based on a sliding scale which factors income and household size. If we are unable to collect payment or arrange a payment plan with you, a payment collections service may be used for payment collections purposes. Please note at the bottom of the page if you would like to be placed on a payment plan. Please specify the day of the month you would prefer to make payments to your account balance and amount (if applicable).

I authorize Touchstone Health Clinic to bill (**name of the Ins. Company**): _____ to pay by check or direct deposit made out directly to:

Touchstone Health Clinic, PLLC.

This is a direct assignment of my benefits and rights under this policy. This payment will not exceed my indebtedness to the assignee and I have agreed to concurrently pay any balances of said services which may exceed this insurance payment.

Signature of Policy Holder: _____

Signature of claimant, if not policy holder: _____

There is a possibility that insurance may not cover your services. This may be because of the following listed reasons.

Potential reasons for Non-Covered Services

- The service is or may be deemed investigational or experimental under the carrier's internal guidelines.
- The service is considered or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
- The service is not or may not be actually covered under the plan to which the patient is subscribed.
- The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for services so long as this disclosure is made and signed by the patient prior to their services being provided.

TouchStone HEALTH CLINIC

Where healing begins

Patient Financial Responsibility:

18.) Since your last visit, has your credit card/bank card information changed? ___ YES ___ NO

If Yes, please provide the following information:

The undersigned patient acknowledges that the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services. We reserve the right to charge 1% on outstanding balances, per Washington State Allowable Laws.

I, _____ Authorize Touchstone Health Clinic, PLLC to charge my credit/debit card for any outstanding balances. For Services rendered.

*Client Name _____

*Credit Card # _____

*Credit Card 3 Digit Code (On Back of Card) _____

*Expiration Date _____

*Billing Address _____

_____

*Zip Code _____

*Name on Card (As it appears on Card) _____

19.) Since your last visit, would you like to change your financial arrangements with Touchstone Health Clinic?
___ YES ____ NO

20.) If Yes, please select from the following:

____ I wish to be placed on a payment plan.
____ I Authorize $ _____ per ___ wk./month
____ I Authorize $ _____ As a onetime payment
____ Preferred Payment Date _____
____ I wish to have my Card charged for Co-Pay $_____ each visit
____ I wish to have my Card charged for Co-Insurance $ _____ each visit
____ I wish to have my Card charged for Deductible $ _____

*Patient Signature: _____ Date: _____

Billing Department Signature: _____ Date: _____

TouchStone
HEALTH CLINIC
Where healing begins

Consent for Purposes of Treatment, Payment & Health Care Operations

I consent to the use or disclosure of my protected health information by Touchstone Health Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment or my health care bills or to conduct health care operations of Touchstone Health Clinic.

I understand that diagnosis or treatment of me by providers at Touchstone Health Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Touchstone Health Clinic is not required to agree to the restrictions I request. However, if Touchstone Health Clinic agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent in writing at any time, except to the extent that Touchstone Health Clinic has taken action in reliance on this consent.

My "protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

Your provider at Touchstone Health Clinic will keep a record of the health care services provided to you. You may ask to see a copy of that record. Your provider will not disclose your record to others unless you direct them to do so or unless the law authorizes or compels them to do so. You may also ask to correct your record. You may also get more information about this by contacting your provider at Touchstone Health Clinic.

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Date: _____

TouchStone
HEALTH CLINIC
Where healing begins

Notice of HIPAA Privacy Practices: Acknowledgement of Receipt of HIPAA Privacy Practices

- I understand I have a right to review Touchstone Health Clinic's Notice of Privacy Practices prior to signing this document.
- Touchstone Health Clinic's Notice of Privacy Practices has been provided to me.
- The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Touchstone Health Clinic.
- The Notice of Privacy Practices for the providers at Touchstone Health Clinic is also provided at the front desk of Touchstone Health Clinic.
- This Notice of Privacy Practices also describes my rights and the duties of the providers at Touchstone Health Clinic with respect to my protected health information.
- Touchstone Health Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
- I may obtain a revised notice of privacy practices by calling the office and requesting revised copy be sent in the mail or asking for one at the time of my next appointment.
- By signing below, I acknowledge that I have reviewed the Notice of Privacy Practices and have had an opportunity to discuss any questions I may have.

Signature of Patient or Personal Representative: _____

Printed Name of Patient or Personal Representative: _____

Date: _____

******For Provider Use Only ******

Client (or personal representative) is unable or unwilling to sign this document for the following reasons:

_____

_____

Describe attempts to obtain Signature: _____

_____

Provider Name: _____ Provider Signature: _____

Date: _____

TouchStone
HEALTH CLINIC
Where healing begins

Notice of Missed Appointment Policy

All appointments are scheduled time between you and your provider; therefore, when an appointment is missed, someone else could have had that scheduled time with the provider.

Twenty-four (24) hour advanced notice is required for an appointment cancellation.

If this notice is not given, Touchstone Health Clinic reserves the right to charge you a $35.00 missed appointment fee. It is important to understand that insurance companies do not pay for this fee.

Please keep your appointments.

Thank-you!

I have read and agreed to the information provided above.

Patient Name: _____ Date: _____

Patient Signature: _____