SOUTH ISLAND MEDICAL
Primary & Immediate Care

Please review and update the information below to the best of your ability.

Patient Info:

Full Legal Name: _____ DOB: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Preferred contact phone, please circle: Home Mobile

Sex assigned at birth: M F Gender Identity: _____ Social Security Number: _____

Email: _____ Language: _____ Race: _____ Ethnicity: _____

Marital Status: _____ Employer: _____

Emergency Contact Name: _____ Relationship _____ Phone: _____

Patient Referred by: _____

Pharmacy Name: _____ Crossroads: _____

Pharmacy Phone: _____

Guarantor if different from patient:
First and last name: _____ Relationship to patient: _____

Address: _____ DOB: _____

Phone: _____ Social Security Number: _____

Insurance to be billed:
Primary: _____ Subscriber if different from patient: _____

DOB: _____ Relationship to patient: _____

Secondary: _____ Subscriber if different from patient: _____

DOB: _____ Relationship to patient: _____

Medicare ID if applicable: _____

PO Box 935/5577 Vanbarr Place, Freeland, WA 98249 Phone 360-331-3343 Fax 360-331-3373

Mark Duncan, MD Dan Fisher, MD. Brook Ott, ARNP
Annette Fly, ARNP Manny Ziegler, ARNP Melody Olson D'Amelio, PA-C
www.southislandmedical.org

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<u>Please sign and date each item below****</u>

ACKNOWLEDGEMENT AND AUTHORIZATION:

- I have read and understand the HIPAA/Privacy Policy for South Island Medical

  Signed_____ Date:_____

- I hereby assign my insurance benefits to be paid directly to the healthcare provider

  Signed_____ Date:_____

- I authorize South Island Medical to release medical information required to process my claim

  Signed_____ Date:_____

- I have read and understand the Financial Policy for South Island Medical

  Signed_____ Date:_____

- I authorize South Island Medical to obtain/have access to my medication history

  Signed_____ Date:_____

- I authorize my provider's office to contact me and leave a detailed message on my _____ phone

  Signed_____ Date:_____

- I authorize my provider's office to contact me on my mobile phone

  Signed_____ Date:_____

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HIPAA Privacy and Release of Information Authorization

HIPPA Privacy and Release of Information Authorization

South Island Medical keeps a record of the health care services we provide to you. You may ask to see and/or receive a copy of your record. You may also ask to add a correction to your record. We will not disclose your record to others without your permission, or unless the law authorizes or compels us to do so. You may see your record or get more information about it at any time.

I, _____ hereby authorize SOUTH ISLAND MEDICAL to use and disclose protected health information for the purpose of helping me to resolve claims and health benefit coverage issues. I also authorize information to be sent for any referrals to other providers for my continuation of care.

I understand that I have a right to revoke this authorization by providing written notice to. I understand that I have a right to have a copy of this authorization.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, and the Assignment of Benefits policy.

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient printed name Date

_____

Patient Signature

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FINANCIAL POLICY

South Island Medical is committed to providing the best possible medical care. The following information outlines financial responsibilities related to payment of services. If you have questions regarding our financial policy or your insurance, contact our office. There may be certain coverage issues that will need to be directed to your insurance carrier.

PATIENT RESPONSIBILITIES
- Patients are ultimately responsible for all charges associated with their care
- Patients must bring their insurance card and picture lD to every visit
- Patients may be required to obtain referrals and/ or authorizations required by their health plans
- Patients must pay their co-pay amounts at each visit

CONTRACTED INSURANCE PLANS South Island Medical (SIM) contracts with a variety of insurance plans. If you are covered by one of these plans, SIM will bill the plan directly. You are responsible for any outstanding balances after your insurance processes the claim.

CO-PAYMENTS AND DEDUCTIBLES Co-payments and deductibles are a contract responsibility between you and your insurance-carrier and may not be negotiated with SIM. Co-payments are due at the time of service.

NON-CONTRACTED PLANS If SIM is not contracted with your insurance carrier, SIM will submit a one-time courtesy billing to the carrier. If payment to SIM is not received within 30 days, all charges are the patient's responsibility and are due immediately.

PATIENTS WITHOUT INSURANCE Payment is due at the time of the visit unless other arrangements are made. A cash discount is extended if the bill is paid at the time of service.

PATIENT FORMS The patient is responsible for charges associated with completing forms required for supplemental health care, disability, family leave or other forms requested that the patient's insurance carrier did not request.

ADDITIONAL CHARGES AND FEES
- SIM will apply a fee for checks returned for non-sufficient funds.
- SIM may charge for missed appointments or for cancelling less than 24 hours prior to the appointment.
- SIM may charge for medical records and for services nor covered by insurance including, but not limited to drafting letters or filling out forms.

UNPAID BALANCES SIM may assign outstanding patient balances to an outside collection agency after severa attempts to work out payments or arrangement with patient.

I authorize SIM to release any information required to process insurance claims and I authorize my insurance company to make payment directly to south Island Medical as appropriate. I agree to pay any outstanding charges within 30 days of receipt, unless payment arrangements have been made.

_____ _____ _____
Patient Signature Printed Patient Name Date

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South Island Medical

Notice of Privacy Practices Acknowledgement and Release to Disclose Information to Third Parties

We keep a record of the health care services we provide to you. You may ask to see and/or receive a copy of your record. You may also ask to add a correction to your record. We will not disclose your record to others without your permission, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer at 360 -331-3343.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you may access your information.

Without your permission, we can only discuss your medical condition and treatment with you. If you would like us to be able to discuss your medical condition and/or treatment with a friend or a relative, you must authorize that communication.

Would you like to authorize use to discuss your medical condition or treatment with a friend or relative?
Discuss your medical condition with a friend or relative?
__ Yes
__ No
If the answer is Yes: Please print their name(s) and contact information below:

These permissions will remain in effect until you give us written notice of any changes.

Name and Relationship	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient or legally Authorized Individual DATE TIME

Printed Name (and relationship if signed on behalf of the patient) _____

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Patient Communication and Information

Thank you for choosing us as your provider! We care about your health and well-being are honored to share in your care and are committed to providing you an excellent experience. Please review the following information for your care here at South Island Medical (SIM).

Medication Refill Information: All refill approvals are at the discretion of your treating provider. Requests from the pharmacy are addressed within 72 business hours. You, the patient, must initiate mail order requests that are for any new prescriptions. Any mail order requests may take a little longer, so please plan ahead.

- Please allow 72 business hours for completion.

Behavior Expectations: We want to provide a safe environment for all patients here at SIM. We agree to treat you kindly and respectfully, remind you of expectations and set reasonable limits. We will listen to you and support you. We will include your family as needed at your approval. In return, we ask that you acknowledge that the following behaviors are not acceptable in our clinics or with our staff:

- Aggressive behavior such as yelling, cursing, swearing, threatening or name-calling. We have a zero tolerance for any type of harassment towards any of our providers, employees or other patients.
- Substance use on clinic property, or otherwise ignoring clinic rules.
- Non-compliance with behaviors or treatment plans determined by you and your provider.

No-Show/Cancellation/Treatment Compliance Policy: To ensure we have access for you and our patients, SIM has the following cancellation and no-show policies:

- **SIM requires all patients to provide 24 hour cancellation notice.** Notice left on our voicemail over the weekend or on a holiday will satisfy this requirement if left 24 hours or more before the appointment time. No-show or less then 24 hour cancelled appointments will be charged $50.
- We request that patients arrive promptly 15 minutes prior to the scheduled appointment time to allow for necessary check-in and insurance verification process. **Not arriving on time could result in a cancelled appointment and inability to be seen.**
- It is important that you discuss and understand your provider's recommended treatment intervals. **Failure to comply with regular scheduled appointments could result in discontinuation of treatment.**

By signing below, I acknowledge reading and understanding these policies and agree to comply.

Signature: _____ Relationship:_____

Date: _____ Printed Name: _____ DOB: _____

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