JAMISON
FAMILY MEDICINE
COMPLETE HEALTH & WELLNESS

9631 N Nevada St, Suite 210, Spokane, WA 99218
Ph: (509) 319-2430 Fax: (877) 568-2402

Patient Information (Please print)

*Patient- Last Name First Middle			*Male ☐ Female ☐	Marital Status ☐S ☐M ☐D ☐Sep
*Mailing Address:	City	State	Zip	*Home Phone #
*Social Security Number	Age	DOB		Cell Phone #
Employer	Occupation	Race		Work Phone #
Spouse's Name	Spouse's Employer			Email Address
Children's Name	Age	Children's Name		Age
Children's Name	Age	Children's Name		Age
*Emergency Contact	Relationship	*Phone #		
Referred by				

Financial Responsibility (This is who billing statements are addressed to)

*Person Financially Responsible	*Phone	*DOB	*Relationship	
Address	City	State	Zip	*Social Security Number
*Employer	Address			*Gender

Medical Insurance

*Name of Primary Insurance	*Policy Holder Name	*DOB	*Identification Number
*Relationship to Patient	*Policy Holder SSN	Group Name	Group Number
*Policy Holder Address if different than patient's			Policy Holder Phone #
Name of Secondary Insurance	Policy Holder Name	DOB	Identification Number
Relationship to Patient	Policy Holder SSN	Group Name	Group Number
Policy Holder Address if different than patient's			Policy Holder Phone #

I hereby give permission to receive treatment and tests deemed necessary by the doctor. I also accept financial responsibility for charges if a service is denied by my insurance. I understand, upon request, medical records could be sent to my insurance company.

*Signature	Relationship if Minor	Date

*= MANDATORY FIELD

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Demographic Data Collection

Federal regulations require that we collect the following information. Your answers are voluntary. Thank you for your cooperation.

1. **Do you consider yourself Hispanic or Latino?** Please choose one.
   - ☐ I am Hispanic or Latino
   - ☐ I am not Hispanic or Latino
   - ☐ Undetermined
   - ☐ Decline to answer
2. **What category best describes your race?** Please choose one.
   - ☐ White/ Caucasian
   - ☐ Black/African American
   - ☐ Native American
   - ☐ Asian
   - ☐ Pacific Islander
   - ☐ Unreported
   - ☐ Decline to answer
3. **What language do you prefer when speaking with your doctor?**
   - ☐ English
   - ☐ Spanish
   - ☐ Russian
   - ☐ Other _____
4. **On-line tools coming soon! Do you have an email address you would like to be contacted through?**

   Email: _____

Patient Name: _____ Date of Birth: _____
Please Print Month/Day/Year

PRIVIA HEALTH

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete, and current, and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider. I authorize my provider, or any holder of medical information about me or the patient named below, to release to my health insurance plan such information needed to determine the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary; however, I may refuse any treatment or procedure at any time.

If I request or initiate a telehealth visit (a "virtual visit"), I hereby consent to participate in the telehealth visit, and I may terminate the visit at any time.

My consent shall cover medical examinations, procedures and testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (such as stitches), cast application/removals, and vaccine administration. My consent shall also cover treatment by care center staff acting under my provider's supervision and direction. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain. My consent shall also cover the use of internal recording devices for the purpose of scribing and clinical documentation improvement. All internal recording adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of

receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

HIPAA. I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.

Printed Name of Patient: _____
Email: _____

Signature: _____
Date: _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

Name and Relationship of Person Signing, if not Patient: _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

PRIVIA HEALTH

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our *Authorization and Consent To Treatment Form* before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out. You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

You are responsible for understanding the limitations of your insurance policy, including:

- If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient).
- What prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit.)
- Any co-payment, coinsurance or deductible that may apply

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork

and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment, you may be charged a $50.00 fee for a missed appointment, a $75.00 fee for a missed pediatric appointment, a $100.00 fee for a missed physical, or a $200 fee for a missed procedure or surgery. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Additional information about our financial policies is available on our website at priviahealth.com.

Thank you for choosing us as your healthcare provider!

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Patient Name: _____ **Date of Birth:** _____

New Patient Information

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

Reason for visit: _____

_____

_____

Allergies: List anything you are allergic to (medications, food, bee stings, etc.) and how it affects you:

_____

_____

Favorite pharmacy: _____

Medications: Please list all the medications you are taking including prescribed, over the counter and supplements (make sure to include strength and how often it is taken, please use separate page if additional space is needed):

_____

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Past Medical History: Circle any of the following that apply to you:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobia	HIV or AIDS	Reflux or Ulcers
Diabetes- Insulin	High Cholesterol	Stroke
Diabetes – Non Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

Immunization History: Please indicate Y/N for immunizations you were given and when. If unknown, which facility would have them on file?

Chicken Pox:	Date:	MMR (Measles, Mumps, Rubella):	Date:
Flu Shot:	Date:	Pneumonia:	Date:
Gardasil/HPV:	Date:	Tdap(Tetanus, diphtheria, pertussis):	Date:
Hepatitis A:	Date:	Tetanus:	Date:
Hepatitis B:	Date:	Zostavax/Shingles:	Date:
Meningococcus:	Date:	Other:	Date:

(Women Only) Obstetric and Gynecological History:

Last pap smear:		Last mammogram:	
Age of first period:		Number of births:	
Number of pregnancies:		Number of miscarriages:	
Last period/Age of Menopause:		Number of cesarean sections:	
Number of abortions		Current sexual partner:	Male or Female
Do you use condoms?	**Y / N**	Method of birth control:	
Interested in STD screen?	**Y / N**		

(Women Only) Circle any of the following that apply to you:

Bleeding between periods	Heavy Periods	Extreme Menstrual Pain	Vaginal itching, burning or discharge	Waking up in the night to use the restroom
Hot Flashes	Breast lump or nipple discharge	Painful intercourse	Sexually Active	Other

Past Surgical History (Please include year, reason, and what hospital and/or doctor if you are able): _____

_____

_____

_____

Family History: Please place a check in the boxes appropriate for your family history.

Relation	Grandmother (M)	Grandfather (M)	Grandmother (P)	Grandfather (P)	Mother	Father	Brother	Sister	Other
Alive?									
Age									
Alcoholism									
Arthritis									
Depression									
Cancer/type									
Diabetes									
Genetic disease									
Heart disease									
Hypertension									
Osteoporosis									
Stroke									
Other									

Social History: Circle the following that apply to you:

Education	Marital Status	Exercise	Caffeine
o <8th grade o High School o 2 Yr college o 4 Yr college o Post Graduate	o Married o Single o Divorced o Separated o Widowed o Domestic Partner	o No Exercise o Occasional Exercise o Moderate Exercise o High Level Exercise	o None o Occasional o Moderate o Heavy _____ # of cups per day?

Alcohol	Tobacco	Drugs
Drink alcohol? Y / N How often? o Occasionally o < 3 times a week o > 3 times a week # of drinks/ week? _____	Do you use tobacco? Y / N If not now, did you ever use tobacco? Y / N o Cigarettes ____ pks/day o Chew _____/day o Cigars _____/day # years used _____ Or years quit_____	Do you currently use recreational or street drugs? Y / N If yes, please list which ones:

PRIVIA HEALTH

Preferred Contacts

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them, such as sending correspondence to the individual's office instead of the individual's home. We invite you to share with us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name:_____ **Date of Birth:**_____

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal.**

☐ **Home Telephone:**_____
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Cell Phone:**_____
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Work Telephone:**_____
- ☐ **OK to leave message with detailed information**
- ☐ **Leave message with call-back number only**

☐ **Written Communication:**_____
- ☐ **OK to mail to my home address**
- ☐ **OK to mail to my work/office address**

☐ **Other:**_____

Preferred Contacts:
We respect your right to indicate who you prefer that we involve in your treatment or payment decisions and/or who we share your information with, including information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up and scheduling appointments. Please note, however, that we may share your information as set forth in our Notice of Privacy Practices to other persons as needed for your care or treatment or the payment of services we have provided. Please update this information promptly if your preferences change.

Please indicate the person(s) you prefer we share your information with below:

•**Name:**_____**Telephone:**_____**Relationship:**_____

•**Name:**_____**Telephone:**_____**Relationship:**_____

•**Name:**_____**Telephone:**_____**Relationship:**_____

Patient Signature: _____**Date:** _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

PRIVIA HEALTH

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____ **Patient's Date of Birth** _____

Address _____ **Patient's Telephone Number** _____

City, State Zip Code _____ **Any Other Names Used** _____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):
   _____
2. Be sent to the following person / entity at the address listed below:
   _____
   Name
   _____
   Address Telephone
   _____
   City State Zip Code Fax or Email Address for Delivery
3. I hereby authorize disclosure of the following information: ☐ My entire medical record ☐ Immunization Records Only ☐ Service Dates Only:
   _____ to _____ ☐ Specific Information Only:
   _____

NOTES

1. INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED.
2. IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; **WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER.☐ PLEASE *EXCLUDE* THE FOLLOWING INFORMATION:**
   _____ **Signature:**_____
3. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. **If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in hard copy/paper format. I hereby request that my PHI be provided in the following format:** ☐ via secure electronic delivery; **or** ☐ other (please specify)_____.
4. If I have requested records be sent **un**encrypted, I understand and acknowledge the risk of sending my PHI in an unsecured manner.
5. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.
6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.
7. I understand I may revoke this authorization by notifying my provider OR privacy@priviahealth.com in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
8. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.
9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify)_____.
10. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire on one year from the date signed.
    _____.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

_____ **Signature of Patient**	_____ **Date of Patient's Signature**	_____ **Patient's Date of Birth**
_____ **If Patient unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate**	_____ **Date of Legal Guardian's/Personal Representative's Signature**	_____ **Description of Authority to Act for the Individual**