REGISTRATION FORM

MILL CREEK FAMILY PRACTICE

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Legal Name:				Preferred Name:
Street Address / PO Box:				Marital Status:
City:	State:	Zip Code:		Employer:
Birth Date: / Age:	Sex: ☐M ☐F	Social Security no.: *(optional)*		Email Address: *(optional)*
Preferred contact method: (circle one) **CELL HOME EMAIL**	**CELL** Phone no.:	**HOME** Phone no.:	**WORK** Phone no.:	

INSURANCE INFORMATION

Please make sure the receptionist is given your insurance card and identification. Any applicable co-pays are due at time of service.

Name of Primary Insurance:		Name of Secondary Insurance: (if applicable)	
Subscriber's Name: __ Self	Subscriber's DOB:	Subscriber's Name:	Subscriber's DOB:
Copayment:	Relation to patient: (spouse, etc.)		Relation to patient: (spouse, etc.)

IF THE PATIENT IS UNDER 18, COMPLETE THIS SECTION

Parent/Guardian's Name:	Birth date:	Parent/Guardian's Name:	Birth date:
Phone no.:	Patient here? ☐YES ☐ NO	Phone no.:	Patient here? ☐YES ☐ NO

OTHER DEMOGRAPHIC INFORMATION *(we are required by law to ask the following questions)*

Preferred Language:	Race:	Ethnicity:
☐ English ☐ Other: _____ ☐ Decline to Answer	_____ Decline to answer	☐ Hispanic/Latino ☐ Non-Hispanic/ Non-Latino ☐ Decline to answer

PREFERRED PHARMACY

Pharmacy Name:	Neighborhood / Cross Streets:	Pharmacy Phone Number:

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which I or my dependents are entitled to under my health insurance plan, as well as release any information by provider or insurance company required for the account. Release if information to include: (1) alcohol and/or drug abuse treatment, (2) psychiatric diagnosis, treatment and summaries, (3) test results for HIV (Human Immunodeficiency Virus), STD (Sexually Transmitted Diseases), and (4) treatment of HIV, STDs, AIDS (Acquired Immunodeficiency Syndrome) and related conditions. I hereby release MCFP from all legal responsibility or liability that may arise from disclosure as provided by this paragraph. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance at 1%per month from the date of service, collection fees, reasonable attorney fees and court costs. I have also been informed of the $50 fee (per RCW 62A.3-515 &620) on checks returned NSF.

Patient OR Legally Authorized Guardian signature ***Date***

P 425.338.4000
F 425.338.4090
www.millcreekfamilypractice.com

Schmidt Medical Center
1025 153rd St. SE, Ste 200
Mill Creek, Washington 98012

Mill Creek Family Practice, PLLC

Notice of Acknowledgement of Privacy Practices and Consent to Discuss Medical Care

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. This is available at the front desk as well as on our website www.millcreekfamilypractice.org. You may see your record or get more information about it by contacting Glynis Thakur, Privacy Officer, at (425) 338-4000.

CONSENT TO DISCUSS MEDICAL CARE

Mill Creek Family Practice, PLLC may discuss my medical information with the following individuals. We may also contact those listed in case of a medical emergency. PLEASE PRINT ALL NAMES LISTED BELOW. PLEASE **DO NOT LIST PHYSICIANS.**

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
EXAMPLE: Jane Doe	Spouse	425-555-1234

VOICEMAIL – CONSENT TO LEAVE DETAILED MEDICAL INFORMATION

I give permission for Mill Creek Family Practice, PLLC to leave detailed medical information at my telephone number(s) below:

☐ ( ) _____ ☐ ( ) _____

OR

☐ **I DO NOT WISH TO HAVE DETAILED MEDICAL INFORMATION LEFT ON VOICEMAIL**

I have reviewed a copy of the Notice of Privacy Practices which provides information about how my health information may be used and disclosed. I have read and understand the Financial Policy of Mill Creek Family Practice, PLLC. I assign payment from my insurance directly to Mill Creek Family Practice, PLLC. I understand that I am financially responsible to MCFP for the charges not paid by insurance and that those charges are due within 30 days of receipt of billing statement. I have authorized MCFP to discuss my medical information with the individuals listed above.

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that MCFP participates in the training of physicians and other healthcare providers and I consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed by MCFP.

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ TODAY'S DATE: _____

Printed Name (If signed on behalf of patient): _____ *Relationship:* _____

MILL CREEK
FAMILY PRACTICE

Consent to Treat Patient – Without Parent /Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name:_____ **DOB**:_____
Last First Middle

Allergies:_____
Current Medications:_____
Chronic Conditions:_____

For those occasions when you may not be with your child, **please list those individuals who may give us consent** to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

LIMITATIONS:
Identify any **specific limitations** on the kinds of medical services for which this authorization is given.
(If none, state "none")

_____

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult,** which shall be in effect for: ☐ Date_____ **Only**
☐ Indefinitely, until revoked by written communication

AUTHORIZATION:
I (parent/legal guardian name)_____request and authorize Mill Creek Family Practice, PLLC and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child, I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Mill Creek Family Practice, PLLC and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations)
I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____
Parent or Legal Guardian (please print) **Relationship**

_____
Parent or Legal Guardian Signature **Date**

Mill Creek Family Practice, PLLC

Financial Policy & Credit Card on File

FINANCIAL POLICY

1. **Payment for all medical care is the patient's responsibility regardless of insurance coverage.**
2. INSURANCE: We participate in most insurance plans and we will bill to your insurance if we are contracted and provided with appropriate documentation. We will also bill most secondary insurances for you. You are responsible for knowing your own insurance benefits and limitations. This includes Accountable Care Networks, Personal Care Networks and/or Limited Network Plans.
3. CO-PAYMENTS: **All copays are due at the time of service.** A $25.00 fee will be charged to any visit at which a copay is not paid at time of service. It is the responsibility of the patient or responsible party to know if your plan requires a copay.
4. NON-COVERED SERVICES: Since the contract between you and your insurance carrier is a private one, we do not routinely research why it has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
5. ACCOUNT BALANCES: **All account balances must be paid within 30 days of receipt of your billing statement.** Failure to pay your balance owed without contacting our Billing Department will result in a delinquent account. If your account remains unpaid, your account may be turned over to an outside collection agency. Any non-sufficient fund checks will be charged a $25 fee. Accounts in Collections are subject to dismissal from the practice.
6. METHODS OF PAYMENT: We accept Cash, Visa, MasterCard and Discover. Established patients may also pay by Check.
7. PERSONAL INJURY CASES: **This office does not bill for motor vehicle accident (MVA), work-related (L&I) or other liability or lawsuit-related cases.** You are responsible for payment at time of service.
8. LATE CANCEL/MISSED APPOINTMENTS: In fairness to other patients and our providers, we ask for at least 24 hours' notice to cancel appointments. If you arrive more than 15 minutes late for your appointment/arrival time, you may be asked to reschedule to another day. **Late cancel (less than 24 hours' notice) and No-Show appointments incur a $50 fee.** If a patient no-shows three or more times within a 12-month period, s/he and any other family members may be dismissed from the practice. It is your responsibility to attend the appointment or give us 24 hours' notice. A confirmatory reminder is a courtesy.
9. DIVORCE/SEPARATION: In cases of divorce and/or separation, the legal guardian and/or the person bringing the child to the **initial visit** will be held financially responsible for payment of medical services.

CREDIT CARD ON FILE

We encourage patients to keep a credit card on file to make the checkout process easier, faster and more efficient. After your insurance has paid its portion of your bill, we will charge your authorized credit or debit card for the amount of the balance. You may specify a maximum amount we may charge your card without contacting you. Credit card numbers are encrypted and stored securely off-site with our bank. No credit card numbers are stored at our office. See "Credit Card on File Frequently Asked Questions" for more information.

I authorize Mill Creek Family Practice, PLLC to keep my credit card on file and charge the portion of my bill that is my financial responsibility.

INITIALS: _____

CARD INFORMATION: *For concern of your privacy, we record the minimum amount of information possible and keep this for verification purposes only.*

☐ **VISA** ☐ **MASTERCARD** ☐ **DISCOVER** **Last 4 Digits:** _____

MAX AMOUNT TO BE CHARGED WITHOUT CONTACTING CARDHOLDER: ☐ $100 ☐ $200 ☐ OTHER $_____

CARDHOLDER NAME: (as it appears on card) _____

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ TODAY'S DATE: _____

Printed Name (If signed on behalf of patient): _____ *Relationship:* _____