

# NEW PATIENT REGISTRATION



DEMOGRAPHIC INFORMATION			
Patient's Legal Name:		Preferred Name:	Marital Status:
Street Address / PO Box:		<b>How did you hear about Mill Creek Family Practice?</b>	
City:	State:	Zip Code:	<input type="checkbox"/> Social Media <input type="checkbox"/> Family/Friend <input type="checkbox"/> Mail/Postcard <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Web Search <input type="checkbox"/> ZocDoc.com <input type="checkbox"/> _____
Birth Date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Email Address: <i>(Securely communicate with your Care Team with our <a href="#">Patient Portal</a>)</i>
PRIMARY/Cell Phone: <i>(req.)</i>		OTHER Phone no.: <i>(optional)</i>	Preferred contact method: <input type="checkbox"/> CELL <input type="checkbox"/> HOME <input type="checkbox"/> EMAIL
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____ <input type="checkbox"/> Decline to Answer		Race: <input type="checkbox"/> _____ <input type="checkbox"/> Multiracial <input type="checkbox"/> Decline to answer	Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Decline to answer
PARENT/GUARDIAN INFORMATION <i>(for patients under 18)</i>			
Mother/Father/Guardian's Name:	Birth date:	Mother/Father/Guardian's Name:	Birth date:
Phone no.:	Patient here? <input type="checkbox"/> YES <input type="checkbox"/> NO	Phone no.:	Patient here? <input type="checkbox"/> YES <input type="checkbox"/> NO
INSURANCE INFORMATION			
<i>Please make sure the receptionist is given your insurance card and identification. Co-pays are due at time of service.</i>			
Primary Insurance:		Secondary Insurance: (if applicable)	
Subscriber: <input type="checkbox"/> SELF	Subscriber's DOB:	Subscriber's Name:	Subscriber's DOB:
Copayment: \$	Relation to patient:	Copayment: \$	Relation to patient:
EMERGENCY CONTACT PREFERENCES			
<i>I allow MCFP to communicate and/or discuss my <b>Protected Medical Information</b> with those listed below.</i>			
<b>Emergency/HIPAA Contact Name</b>	<b>Relationship to Patient</b>	<b>Phone Number</b>	
May we leave <b>detailed voicemail</b> on your primary contact number? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PREFERRED PHARMACY			
Pharmacy Name:	Neighborhood / Cross Streets:	Pharmacy Phone Number:	
PATIENT ACKNOWLEDGMENTS			
<p>I have read and understand the <u>Financial Policy</u> of Mill Creek Family Practice, PLLC. I have reviewed a copy of the <u>Notice of Privacy Practices</u> which provides information about how my health information may be used and disclosed. I assign payment from my insurance directly to Mill Creek Family Practice, PLLC, and I 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. I allow disclosure of patient's Protected Health Information (PHI) to the individual(s) listed above. I hereby release MCFP from all legal responsibility or liability that may arise from disclosure as provided by this paragraph. 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 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. I authorize treatment of the person named above and agree to pay all fees for such treatment. 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. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance from the date of service, collection fees, reasonable attorney's fees and court costs. I have also been informed of the \$50 fee (Per RCW 62A.3-515 &amp; 620) on returned checks NSF.</p>			
X			
SIGNATURE <i>(Patient or Parent/Authorized Representative)</i>			Today's Date

# Mill Creek Family Practice, PLLC

## Financial Policy

*The providers at Mill Creek Family Practice are committed to providing excellent and affordable care to all of our patients. Your understanding of our Financial Policy, and any changes therein, is important to the establishment and continuation of our relationship as Patient and Provider.*

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.
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. **PRIVATE PAY APPOINTMENTS:** A \$90-\$150 deposit is required at check in for all patients paying out of pocket for their appointment. At the end of your visit, your card will either be charged the remaining balance, or refunded the difference if the cost of the appointment is less than the deposit made.
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 and major Credit Cards. 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 minor patient to the **initial visit** will be held financially responsible for payment of medical services..

## Authorization – Payment Card on File

Due to changes in Healthcare Policy and increasing high-deductible Health Insurance plans, we have unfortunately experienced higher numbers of patients with unpaid medical bills. Therefore, we have implemented a new policy in which ***all patients are required to provide a credit card to be kept securely on file for future account balances.***

Please note that this does not change your existing rights with respect to the use of your card. You are still able or ask for investigation into your insurance company's decision on a claim. Card numbers are stored securely off-site with our bank. Card numbers are not kept in our office.

Co-pays will remain due at time of service as part of the contract between patient and insurance company. We will bill your insurance company(s) following your visit. They are required to send us and you a copy of the Explanation of Benefits letter detailing what amount was covered/paid by your insurance, and what, if any, amount is owed by you, the patient. The card on your account will be charged as payment in full for any remaining balance not paid by insurance. You will receive receipts via email as long as we are provided with your email address.

Transactions are run as credit, not debit, and are listed as "Mill Creek Family Practice" on your credit card statement. If you have any questions about this policy, please contact our Billing office by phone at (425)338-4009.

**I have read and understand Mill Creek Family Practice's Financial and Credit Card Authorization Policy and I agree to its terms as stated.**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

CARDHOLDER:  Same as Patient \_\_\_\_\_ AUTHORIZED LAST 4 DIGITS: \_\_\_\_\_

CARDHOLDER SIGNATURE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

Printed Name (If signed on behalf of patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

**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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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

## CHILD/ADOLESCENT HEALTH HISTORY FORM

(4 to 17 years)

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Current Concerns: \_\_\_\_\_

Previous Illnesses/Hospitalizations: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

School: \_\_\_\_\_

Sports/Hobbies/Interests: \_\_\_\_\_

### Immunizations and Dates

Hep A #1	Hep A #2	Hep B #1	Hep B #2	Hep B #3
Pevnar #1	Pevnar #2	Pevnar #3	Pevnar #4	
HIB #1	HIB #2	HIB #3	HIB #4	
IPV #1	IPV #2	IPV #3	IPV #4	
MMR #1	MMR #2	Tdap		
DTaP #1	DTaP #2	DTaP #3	DTaP #4	DTaP #5
Menactra #1	Menactra #2	Varicella #1	Varicella #2	
HPV #1	HPV #2	HPV #3		
Rotovirus #1	Rotovirus #2	Rotovirus #3		

### Family History

*Check the box if any relative has had that condition/disease. Please write the relationship to the patient.*

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Developmental Delay
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Allergies/Asthma/Hayfever
<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Obesity
<input type="checkbox"/> Thyroid Trouble	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Other:

Smokers at home? \_\_\_\_\_

Pets at Home? \_\_\_\_\_