Best PRACTICES
MEDICAL CLINIC
Where the patient is always priority.

Thank you for choosing Best Practices Medical Clinic as your medical provider!

Prior to being able to schedule a first visit, we need to request some important information about you. Please print and read through the following documents contianed here. After they are signed please return them to our clinic.

If you have any questions or need help filling in the forms, don't hesitate to give us a call at 509-426-2378.

After you have returned the forms to our clinic and the clinic owner Greg Swart ARNP has opportunity to review the information, you will be contacted to schedule your first appointment

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PLEASE PRINT

Date:___/___/____
Last Name:_____ First Name:_____ Middle Name:_____
Previous Last Name:_____ D.O.B: ___/___/____ SSN:____-____-____ Sex: M F
Guardian Name (If patient is a minor):_____ Relation:_____
Street Address:_____ Mailing Address:_____
City:_____ State:_____ Zip:_____
Home Phone:_____ Work Phone:_____ Mobile Phone:_____
Contact Preference:_____ Email Address:_____
Marital Status:_____ Name of Partner/Spouse/Significant Other:_____
Language:_____ Race/Ethnicity: ___White ___African American ___Asian
___White/Hispanic ___Non-White Hispanic ___American Indian or Alaskan Native
Person Responsible for Bill:_____ Relation:_____

Patient Employed by:_____
Business Address:_____ City:_____ State:_____ Zip:_____
Business Phone:_____ Occupation:_____

Spouse/Responsible Party Employed by:_____
Business Address:_____ City:_____ State:_____ Zip:_____
Business Phone:_____ Occupation:_____
Spouse/Responsible Party SSN:_____-____-_____

Do you have Medical Insurance? Circle One: Yes No If yes, please fill in the following information:
Name of Primary Insurance:_____ ID#:_____ Group #:_____
Subscriber's Name:_____ D.O.B: ___/___/____
Insurance Address:_____ City:_____ State:_____ Zip:_____

Name of Secondary Insurance: _____ ID#:_____ Group #:_____
Subscriber's Name:_____ D.O.B: ___/___/____
Insurance Address:_____ City:_____ State:_____ Zip:_____
*This information is required by HIPPA

In case of emergency, who should be notified?_____
Relationship:_____ Home Phone:_____ Mobile Phone:_____
Preferred Pharmacy:_____ How did you hear about us?_____
Previous Primary Care Provider/Clinic:_____

Patient Health Questionnaire

Date:_____ **Name:**_____

Date of Birth:_____ **Pharmacy:**_____

What are you requesting to be seen for today:_____

_____

Have you been seen for this issue before? ☐ **Yes** ☐ **No**
And if so, by whom and when?_____

_____

Do you have any chronic medical issues? ☐ **Yes** ☐ **No**
If yes, please list:_____

_____

_____

Are you currently taking any prescription medicines? ☐ **Yes** ☐ **No**
If yes, please list:_____

_____

_____

Do you have any medication allergies ☐ **Yes** ☐ **No**
If yes, please list medication and reaction:

_____

_____

Do you have any serious food allergies ☐ **Yes** ☐ **No**
If yes, please list medication and reaction:

_____

_____

Who is your current primary care provider:_____

How were you referred to our office?_____

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Best Practices Medical Clinic all benefits, if any, otherwise payable to me for his/her
(Provider's Name)

services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Best Practices Medical Clinic
(Provider's Name)

will be credited to my account, in accordance with the above said assignment.

_____ _____
(Authorized Signature of Subscriber) (Date)

Financial Policy

I have read and understand the financial policies of Best Practices Medical Clinic. By my signature, I agree to the terms outlined in the financial policies.

_____ _____
Signature Date

Consent for Treatment

I (or my legal guardian/parent) authorize Best Practices Medical Clinic to provide medical care reasonable by today's standards.

_____ _____
Signature of Patient/Legal Guardian Date

Best PRACTICES MEDICAL CLINIC
Where the patient is always priority.

5 South 14th Ave • Yakima, WA 98902
Phone: 509 426-BEST (2378) Fax: 509 426-2380

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Best Practices Medical Clinic Fax (509)426-2380 Ph: (509) 426-2378

Address: 5 South 14th Avenue

City: Yakima State: WA Zip Code: 98902

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES A YEAR AFTER IT IS SIGNED.

Code of Conduct Contract

The staff at Best Practices Medical Clinic is expected to treat each patient and each other with the utmost respect and care. We ask that, as a patient, you do the same.

What it is: The patient code of conduct outlines proper behavior for the patient. Patients seeking medical care responsible for their own personal and environmental well-being. For many, the code of conduct seems simple to follow. Unfortunately, because boundaries have been overstepped in the past this contract has become necessary.

HEALTH AND INSURANCE RESPONSIBILITIES: As a patient, you must give the provider you're accurate and complete medical history. Notify the provider of any pre-existing conditions. Inform the provider of any changes or symptoms. You must also follow your provider's treatment plan. If you do not understand the diagnosis, ask questions. Also, it is the patient's responsibility to be informed and educated when it comes to personal health and insurance coverage.

Patient's Behavior: Patients must follow the rules and regulations set forth by the clinic. As a patient, you must treat healthcare professionals and their staff with respect. Inappropriate behavior will not be tolerated. This includes verbal abuse, such as bullying in an attempt to get one's way. Patient should pay all bills promptly. In addition it is important for patients to have a realistic expectation of what a provider can do to help the patient and what you as the patient have control over.

If the code of conduct is not followed you may be asked to leave the clinic and be discharged from our practice, Effective immediately.

We appreciate your understanding in this matter and look forward to being a partner in your healthcare needs.

I agree to follow the code of conduct as outlined above:

_____ _____

Patient or Legal Guardian Signature Date

_____

Print Patient Name

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for BEST PRACTICES MEDICAL CLINIC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand revisions of Privacy Practices can be made at any time. A revised Notice of Privacy Practices may be obtained by submitting a written request to the office.

With this consent, BEST PRACTICES MEDICAL CLINIC may text, email or call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATEMENT, PAYMENT AND HEALTHCARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, BEST PRACTICES MEDICAL CLINIC may text, email or mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS, such as appointment reminders, patient statements and payment receipts.

With this consent, I agree to allow BEST PRACTICES MEDICAL CLINIC to text, email or mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS, such as appointment reminders, patient statements and payment receipts. I have the right to request that BEST PRACTICES MEDICAL CLINIC restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow BEST PRACTICES MEDICAL CLINIC to use and disclose my PHI to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, BEST PRACTICES MEDICAL CLINIC may decline to provide treatment to me.

Signed By: _____ _____ _____

Patients Signature or Legal Guardian | Date | Relationship to Patient

_____ _____

Print Patient's Name | Print Name of Legal Guardian if Applicable

FINANCIAL POLICY

Thank you for choosing Best Practices Medical Clinic (BPMC) as your healthcare provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment for services is a part of that relationship. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

PATIENT INFORMATION:

A fully completed, current patient registration will be on file in the patient's chart during the time in which the patient is considered an active patient. Patient registrations will be updated by the patient yearly and will include where the patient can be reached by phone. A signature by the responsible party is required.

INSURANCE CLAIMS:

Primary insurance – BPMC will file claims with the patient's insurance upon the patient's submission of proof of insurance, (i.e. insurance card indicating coverage, identification number and group number). In the event the patient has insurance coverage but cannot provide documentation, payment is due at the time of service. The patient is responsible for supplying information requested by the insurance company (i.e. annual claims forms, accident details, etc.). Upon receipt of the insurance card, BPMC will submit the health claim form indicating patient payment at the time of service.

Secondary Insurance – Claims will be filed with secondary insurance if adequate information is received at the time of service. However, if payment is not received in our office within 45 days after filing, the responsibility will be transferred to the patient and due upon receipt.

PATIENT FINANCIAL RESPONSIBILITY:

If no insurance is to be filed by BPMC or BPMC is not a participating provider, full payment is due at the time of service. If you are paying out of pocket for your visits a 20% discount will be given when you pay in full at the time of service. Co-payment, deductibles, co-insurance, and non-covered services are due at the time of service. For your convenience, we accept cash, checks, Visa, and Master Card. Payment arrangements can be made with the approval of management. Balances $200.00 or greater will require a payment of at least 50% plus the copay (if applicable) due at the appointment.

MINOR/DEPENDENTS:

Children under the age of 18 will required the signature of a responsible adult party on the registration form.

FINANCIAL POLICY

ACCOUNTS PAST DUE:

Payment from a statement is due upon receipt. Non-payment may result in preparation of the account for small claims court, collections agency, and/or credit bureau reporting and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including reasonable attorney fees of no less than 30% and court costs. A patient may remit in full for all outstanding charges owed on an account. Amounts previously placed with a collection service will need to be paid to the collection service. If the patient has been discharged from the practice for non-payment of their account, the provider may reserve the right to re-establish the patient to active status in the practice once the account has been paid in full. Once returned to active status, the patient will be expected to pay in full at the time of service for all subsequent visits.

MISSED APPOINTMENTS:

BPMC requires a 24 hour notice of appointment cancellation. Appointments missed that are not previously cancelled will be charged a "no-show" fee of $50.00 for established patients and $75.00 for new patients. After 2 "no-show" appointments, the patient will not be able to schedule an appointment but will be seen on a same day appointment as availability allows.

Other services requiring cash payment at the time of service:

Completion of paperwork/forms	1st page $25, any additional $10 per page
Copy of chart notes	Pages 1-30 $1.17/page, $0.88 for each additional page plus a $26 clerical fee,
Returned checks (NSF fee)	$40

ACCOUNT QUESTIONS:

Please feel free to contact our office if you have any questions regarding our financial policy

At 509-426-2378.

I have read and agree to Best Practices Medical Clinic's Financial Policy.

_____ _____

Patient or Legal Guardian Signature Date

_____

Print Patients Name

1. I have read and agree with the terms outlined in the financial policy.

2. I give consent for my medication history to be electronically downloaded from my pharmacy(s) into the electronic medical record used by Best Practices Medical Clinic.

3. I give consent for any immunizations/vaccines given at Best Practices Medical Clinic to be electronically downloaded into the Washington State Immunization Information System (Best Practices Medical Clinic is interfaced with the registry).

4. The Patient Notice of Privacy Practices is available at my request.

5. Patient Portal information is available at my request.

Patient/Guardian_____Date_____

Annual Physical, Preventative or Wellness visit:

Physical exams may include:

Pediatric – Development & Growth

Female – Pap Smear & Breast Exam

Male – Prostate & Testicular Exam

Skin Check

Healthy Lifestyle discussion

Immunizations

Lab testing as appropriate

Coordination of care/referrals for additional screening:

Mammograms

Colonoscopies

Eye Exams

Other as indicated

An Office Visit, Sick Visit or Medication Check

These are appointments where we discuss and evaluate existing or new concerns with medical conditions:

Evaluate & Treat symptoms or concerns

Address chronic problems

Adjust medication & process refills

Review Laboratory testing results or order Laboratory tests as needed

Process referrals as necessary

- Please note than many insurances will not pay for a Physical and Office Visit on the same day. You may need to schedule two separate appointments.

Confidential Communications Form (HIPAA)

In order to protect your privacy we need your written permission to give personal health information to anyone besides you. However it should be noted, our current notice of privacy practices does allow us to contact you with a courtesy reminder regarding any upcoming appointments. This PHI can be released in any of the following forms: hard copies, verbally or electronically. This information can include a number of things including but not limited to: lab or imaging results, orders, referrals, historical medical records, medication lists, vaccination history, encounters and procedures and administrative documents.

Please complete the following to let us know whether or not we can leave information regarding your medical information and with whom we may leave it with.

Please choose one of the following:

☐ **I DO CONSENT to release personal health information as follows:**

I, _____, give **Best Practices Medical Clinic** and their staff my permission to release information regarding my medical care with the following options: **(Initial each one that applies)**. This will remain in effect until you rescind it in writing.

_____ Leave a detailed message on home phone _____ or cellphone _____
Phone number phone number.

_____ My spouse (name) _____

_____ Other (name) _____

Signature: _____ Date: _____

☐ Revocation of prior consent:

I, _____, wish to rescind or stop the previous authorizations.

Signature: _____ Date: _____