Northwest OB-GYN Patient Information

105 W. Eighth Ave. • Suite 6020 & 6025• Spokane, WA. 99204• (509) 455-5050

GENDER: Female

Today's Date______________ Date of first Appointment_______________ With _______________________

PATIENT

Legal Name____ Date of Birth _________________

First Middle Last

Age______ Social Security # ______-______-______ Nickname (if you use one) ________________________

Address____

Street address City State Zip

Home Phone (_____) ___________ Work Phone (______) ____________ Cell Phone (_____) _____________

Which is the best Number to reach you at during the Day? ☐ Home ☐ Work ☐ Cell

Email Address_________________________ Referred by__________________☐ Friend ☐ Physician ☐ other

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race/Ethnicity ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White

☐ Black or African American ☐ Hispanic or Latin ☐ Other Race please list______________________

What is your primary language? _________________________

Do you have any special needs? ☐ Language ☐ Mobility ☐ other, please list _______________________

Are you a student? ☐ Yes ☐ No ☐ Full time ☐ Part time

Employer Name __________________________ ☐ Full time ☐ Part time Job title ____________________

Emergency Contact (other than Spouse) ____

Relationship _________________________________ Number (____) __________________________________

Do you have a Primary Care Physician outside of this office? ☐ Yes ☐ No Name _____________________

What Pharmacy do you use most often? Name_______________________ Location __________________

SPOUSE

Name ___________________________ Date of Birth _____________ Social Security # ______-______-____

Employer Name ____ Phone (____) _____________________

MINOR

Name of Parent or Guardian ___________________________ May we contact them at work? ☐ Yes ☐ No

Parent/Guardian employed by___________________________ Work Phone # (______) _________________

INSURANCE

Primary Insurance Name _____________________

Subscriber's Name__________________________

Subscriber's DOB ___________________________

ID# _________________ Group # ______________

Address____________________________________

Phone # __________________________________

Relationship to subscriber: ___________________

Secondary insurance Name _____________________

Subscriber's Name ___________________________

Subscriber's DOB ____________________________

ID#_________________ Group # ________________

Address______________________________________

Phone # _____________________________________

Relationship to subscriber: ______________________

Insurance Release of Benefits and Information

I authorize my insurance company benefits to be paid directly to the doctor. I am financially responsible for any balance due, including for service exceeding the limits of my insurance policy. I authorize the doctor or insurance company to release any information requested for claims.

Patient's Signature ____ **Date** ___________________________

Note: In order to control our costs, we request that our office visits or co-payments be paid at the time of service is rendered. We would rather control our billing cost than be forced to raise our fees. Please indicate below how you wish to pay for your services. ☐ Cash ☐ Visa/ MasterCard ☐ Personal Check

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HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY

Northwest OB-Gyn
Effective date: March 4, 2011

COMPLETE HIPAA NOTICE OF PRIVACY PRACTICES AVAILABLE UPON REQUEST

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

<u>To Parties required or allowed by laws and regulations, including but not limited to:</u>

- For treatment, payment, health care operations and appointment reminders
- As required by the Military or Veterans and Workers' Compensation
- For Public Health risks
- For Health oversight and accountability activities
- For Lawsuits and disputes
- For Coroners and, health examiners
- For National Security, Protective Services and Intelligence activities

Your rights regarding Your Personal Health Information (PHI) are:

- The Right to Inspect and Copy
- The Right to Amend your PHI
- The Right to an Accounting of Disclosures
- The Right to Request Restrictions of Disclosure
- The Right to Request Confidential Communications
- The Right to a Paper Copy of this Notice (*full Notice is available upon request*)

Changes to this Notice:
We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date on the first page.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact Robert Walker Compliance Officer or our COO, Susan Legel to file a complaint.

Acknowledgement of Receipt of this Notice:
We request that you sign below to acknowledge you have received seen this notice. This acknowledgement will become part of your medical record.

X____

Please sign above to indicate you received this notice. Today's Date

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