



NORTHWEST OB·GYN

105 West 8th Ave, Suite 6020
Spokane, WA 99204
509-455-5050

Legal Name _____ Preferred _____

Date of Birth _____ SSN: _____ Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Msg ok? yes no Employer Name _____ Work Phone _____

Would you like emailed appointment reminders and access to your records via our patient portal, yes no

If yes please provide email address:

Race/Ethnicity American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander White
 Black or African American Hispanic or Latin Other Primary Language _____

Do you have a Primary Physician _____ Pharmacy _____

Whom may we thank for referring you?

Emergency Contact Name _____ Relationship _____

Phone _____

Primary Insurance Name _____ Subscriber's Name _____

Subscriber's DOB _____

Secondary Insurance Name _____ Subscriber's Name _____

Subscriber's DOB _____

Do you have special needs Language Mobility Other please list _____

Release of Benefits and Information

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

Signature _____ Date _____

HIPAA NOTICE OF PRIVACY PRACTICES SUMMARY

Northwest OB-Gyn

Effective date: September 23, 2013

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:

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

- 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 addressed to our Security Officer.

Acknowledgement of Receipt of this Notice:

We request that you sign below to acknowledge you have received this summary of the HIPAA notice. This acknowledgement will become part of your medical record.

X

Please sign above to indicate you received this notice.

Today's Date