Family Medicine Center, P.S.
Sumathy Pathy, MD
11420 NE 20TH STREET,SUITE A
Bellevue, WA 98004
Tel No: (425) 646-7800
Fax No: (425) 646-8828

PATIENT INFORMATION

A. Patient Demographics

Last name:		**First Name/ MI:**	
SSN:	**DOB:**	**Sex:** ☐ Female ☐ Male	**Marital Status:**

Mailing Address:	**Apt #:**	**City/State:**	**Zip code:**

PHONE NUMBERS:

Home:

Work:

Cell:

Fax:
Pager:

Occupation:	**Employer:** School:
E-mail Address: (Required)	

B. Patient Insurance

PRIMARY INSURANCE Company Name:	Member/Policy No:
Policy Holder's Name:	Group No:
Employer's Name:	Policy Holder's DOB and SSN:

SECONDARY INSURANCE Company Name:	Member/Policy No:
Policy Holder's Name:	Group No:
Employer's Name:	Policy Holder's DOB and SSN:

C. Emergency Contact **(Required)**

Name:	Phone No(s):

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE POLICY AND PRIVACY PRACTICES

Office Policy: The policies provide information on how I can help the office run smoothly as well as aide in the quality healthcare I receive. I understand that I should read it carefully. I am aware that the policy may be changed at any time. I may obtain a revised copy of the Policy by calling (425) 646-7800.

Initials _______

Privacy Practices: The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (425) 646-7800.

Initials _______

In general the HIPAA rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that communications of their protected health information take place by alternative means, such as sending correspondence to the individual's work place instead of home.

I wish to be contacted in the following manner: (Please check all that apply)

Home Telephone

____Leave Detailed message

____Leave call back number

____Speak with spouse/significant other Regarding billing/scheduling

Work Telephone

____Leave Detailed message

____Leave call back number

Written communication, i.e.:

Mail to home address____

Mail to work address_____

Fax to this number ___________

______________________________ Signature

___________ Date

______________________________ Printed Name

As the representative of the above individual, I acknowledge receipt of the Office Policy and Privacy Practices on his/her behalf.

______________________________ Signature and Relationship to Patient

___________ Date

PLEASE FILL OUT HIPAA CONSENT ON THE BACK OF THIS PAGE →→→→→→

HIPAA PATIENT CONSENT FORM

I hereby give my consent for Family Medicine Center, P.S. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Family Medicine Center, P.S. describes such uses and disclosures more completely.)

With this consent, Family Medicine Center, P.S. may 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 TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Family Medicine Center, P.S. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Family Medicine Center P.S. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Family Medicine Center, P.S. restrict how it uses or discloses my PHI to carry out TPO. 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 Family Medicine Center, P.S. to use and disclose my PHI to carry out TPO.

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, Family Medicine Center, P.S. may decline to provide treatment to me.

______________________________ ______________

Signature of Patient or Legal Guardian Date

____

Print Patient's Name

____

Print Name of Patient or Legal Guardian, if applicable