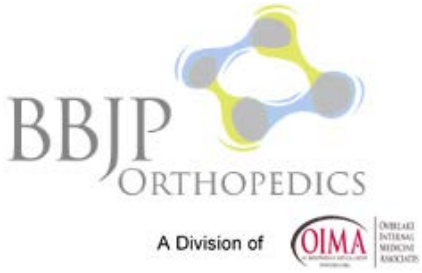
New Patient Intake Form



Please complete information below

Today's Date: _____

Name: _____DOB_____Age_____ ☐ Male ☐ Female

Referring Physician_____FAX_____
Address _____ Phone _____

Primary Care Physician_____ FAX _____
Address _____ Phone_____

Is this a work related problem? Yes ◯ No ◯ If yes, list your OWCP or L&I #_____
If disabled, when did you last work? _____

Is this a Motor Vehicle Accident related problem? Yes ◯ No ◯

Do you currently reside in a skilled nursing facility? Yes ◯ No ◯
If so where? _____
From what dates? _____

Chief Complaint: _____ ☐ Right ☐ Left ☐ Both

When did this problem begin (date of injury):_____ Hand Dominance? Right ☐ Left ☐

How did it happen: _____

Select the symptoms that best describe your problem: Stiffness ☐ Pain ☐ Instability ☐ Numbness ☐ Swelling ☐
Other_____

If you have pain, please select the description that is most appropriate:
Sharp ☐ Throbbing ☐ Aching ☐ Burning ☐ Stabbing ☐ Heavy ☐ Dull ☐

Select the number corresponding to the intensity of vour pain:
(0 = no pain and 10 = the worst pain imaginable) 0

How are your symptoms changing?
Better Gradually ☐ Better Rapidly ☐ Worse Gradually ☐ Worse Rapidly ☐ Staying the Same ☐

Select what improves your symptoms? Rest ☐ Ice ☐ Heat ☐ NSAID ☐ Splinting ☐ Massage
Other_____

Select what worsens your symptoms? Activity ☐ Cold ☐ Pressure ☐ Other_____

What studies or treatments have you had for this problem? (Circle all that apply)
X-rays ☐ CT ☐ MRI ☐ Nerve study (EMG) ☐ Arthrogram ☐ Bone Scan ☐ Surgery ☐

Social History

What is your height and weight?
Height in feet and inches _____ Weight in pounds _____

Do you smoke?
Yes ◯ No ◯ If yes, how much of a pack per day?____ How many years have you been smoking? _____

Were you previously a smoker?
Yes ◯ No ◯ If yes, when did you quit and how long did you smoke for? _____

Do you have any children?
Yes ◯ No ◯ If so how many children? ____

Do you drink alcohol?
Yes ◯ No ◯ If yes, how many drinks per week? ____

Do you drink caffeine?
Yes ◯ No ◯ If yes, how many drinks per week? ____

Do you following a specific diet?
Yes ◯ No ◯ If yes, which diet? _____

Have you ever had a drug or alcohol problem? If yes, please specify
Yes ◯ No ◯

Work status?
Employed ☐ Unemployed ☐ Disability ☐ Student ☐ Retired ☐ Homemaker ☐

Occupation_____ Highest level of education_____

Do you exercise?
Yes ◯ No ◯ If yes, how many times per week? ____ What type of exercise? _____

Marital Status?
Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner ☐

Personal Medical History

Please check if you have a history of any of the following,

Allergies ☐	Anxiety ☐	Asthma ☐	Bipolar ☐
Bleeding Disorder ☐	Cancer ☐	Chronic Lung Disease ☐	Coronary Artery Disease ☐
Congestive Heart Failure ☐	Depression ☐	Diabetes ☐	DVT/Clotting Disorder ☐
Fibromyalgia ☐	Heart attack ☐	Heartburn/reflux ☐	Hepatitis ___ (specify type) ☐
High Blood Pressure ☐	High cholesterol ☐	Kidney Disorder ☐	Liver Disorder ☐
Neck Fusion ☐	Psoriasis ☐	Rheumatoid Arthritis ☐	Sleep Apnea ☐
Dementia/Alzheimer's ☐	Thyroid Disorder ☐	Stroke ☐	Other _____

Family History

Please identify if any of your family members have had the following,
PLEASE SPECIFY WHICH FAMILY MEMBERS (Indicate maternal or paternal when applicable)

Diabetes _____	High Blood Pressure _____	Stroke _____	Heart attack _____	Cancer _____
Depression _____	Kidney/ Liver Disease _____	Rheumatoid _____	Gout _____	Bleeding Disorder _____
Arthritis _____	Autoimmune _____	DVT/Clotting Disorder _____	Other _____	

Surgical History

Surgeries: (Please **select** all that apply)	Year	Other surgeries Procedure	Year	L or R
No previous surgeries				
Appendix (appendectomy)				B/L
Gall bladder (cholescystectomy)				B/L
By-pass/open heart (CABG)				B/L
Hernia repair				B/L
Hysterectomy				B/L
Tonsils removed (tonsillectomy)				B/L
C-Section				B/L

Allergies

Please **select** if you have any of the following allergies and specify your reaction

No Known Drug Allergies ☐	Erythromycin _____	Codeine _____
Iodine _____	Penicillin _____	Others:_____
Sulfa _____	Latex_____	

Current Medications: Dose: Times per day: Reason you are taking

1._____
2._____
3._____
4._____
5._____
6._____
7._____

*OR ATTACH LIST OF MEDICATIONS ☐

Review of Systems

	Yes	No	Comments
General (weight gain/loss, fatigue, insomnia, fever/chills)	☐	☐	
Eyes (glasses/contacts, cataracts, glaucoma)	☐	☐	
Ear/Nose/Throat (sinus trouble, hearing loss)	☐	☐	
Heart (chest pain, high blood pressure, coronary artery disease, irregular heartbeat)	☐	☐	
Lungs (shortness of breath, asthma, lung disease)	☐	☐	
Stomach (heartburn, nausea, diarrhea, hepatitis)	☐	☐	
Muscle / Bones (joint pain, muscle pain, arthritis, fractures, sprains)	☐	☐	
Urinary Tract (painful urinating, kidney stones, prostate)	☐	☐	
Skin (masses, blisters, dermatitis, eczema)	☐	☐	
Neurologic (seizures, numbness/tingling)	☐	☐	
Mental Health (anxiety, depression)	☐	☐	
Endocrine (frequent urination, excessive thirst, diabetes, hypothyroid)	☐	☐	
Hematological (bleeding/clotting problems, anemia, swollen lymph nodes)	☐	☐	
Allergic / Immunologic(HIV/AIDS, hay fever lupus)	☐	☐	

Overlake Internal Medicine Associates, P.S.
Patient Profile

REFERRAL INFORMATION

Referred by Physician? ◯ Yes ◯ No

Referring Physician Name: _____

Referred by other (e.g., patient, website, ad) _____

PREFERRED PHARMACY

Pharmacy Name: _____

Location/Neighborhood: _____Phone:_____

By signing below, I hereby authorize Overlake Internal Medicine Associates, P.S. to obtain my Medication History from Community Pharmacies and/or Pharmacy Benefit Managers for the purpose of Continued Treatment.

Printed name: _____

Signature: _____ Date: _____

OTHER DEMOGRAPHICS – *(Federal Law Requires That We Ask the Following)*

Preferred Language: ◯ English ◯ Other: _____ ◯ Decline to answer

Race:
- ☐ White
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Decline to Answer

Ethnicity: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino** ☐ **Decline to answer**

EMERGENCY INFORMATION

Person to contact: _____ Phone #: _____

Relationship to patient: _____

May we take your photo to enhance your patient record? ◯ **Yes** ◯ **No**

The information contained in this document is true to the best of my knowledge. I understand that I am responsible for charges associated with medical services and agree to pay all bills from Overlake Internal Medicine Associates within 30 days of receipt of statement, unless other arrangements are made in advance. I authorize the physicians and Overlake Internal Medicine Associates to release any information required to process my insurance claim. I also authorize payment of insurance benefits directly to Overlake Internal Medicine Associates.

Printed name: _____

Signature: _____ Date: _____

For official use only: Patient account number _____

Authorization for BBJP/Overlake Internal Medicine Associates, P.S. (OIMA) to Use or Disclose Protected Health Information

BBJP ORTHOPEDICS
A Division of OIMA

Patient name: _____ Date of birth:_____

I. The following is my authorization as it pertains to persons other than my healthcare providers (family, friends, business persons, etc.):

BBJP/OIMA may use or disclose this health care information with/to: Name or title and relationship or organization:

_____

_____

Address(es) (optional): _____

Reason(s) for this authorization to use or disclose my health care information (☒ all that apply):

☐ my preference unless or until revoked ☐ other business purpose (specify)_____

BBJP/OIMA may use or disclose the following health care information (☒ all that apply):

☐ All health care information in my medical record
☐ Health care information in my medical record relating only to the following treatment(s) or condition(s):

_____

☐ Health care information in my medical record for the date(s): _____
☐ Other (e.g. X-rays, bills, appt. dates/times), specify): _____

Uses and Disclosures Requiring Specific Authorization

BBJP/OIMA may use/disclose health care information regarding tests, diagnosis, and treatment for (☒ all that apply):

☐ HIV/AIDS ☐ Drug and/or alcohol use ☐ Mental health or illness
☐ Sexually transmitted diseases ☐ Reproductive care (minors only)

Minors- a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

This authorization ends:

☐ on (date): _____ ☐ when the following event occurs: _____
☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) from BBJP/OIMA. However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies or
   - to receive health care when the purpose is to create health care information for a third party.

2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by BBJP/OIMA in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form which is available from BBJP/OIMA, or write a letter to BBJP/OIMA

III. Protection after Disclosure. I understand that once my health care information is disclosed, the person or entity that receives it may re-disclose it, which is beyond the control of BBJP/OIMA and the protections intended by this form.

_____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name (if signed on behalf of the patient) Relation (parent, legal guardian, personal rep)

_____ _____
Minor patients signature, if applicable Date Time

BBJP ORTHOPEDICS

A Division of OIMA Overlake Internal Medicine Associates

Authorization to Leave Detailed Medical Messages

Including Voicemail, In-Person, or Other Authorized Forms of Communication

To an adult(s) age 18 or over only

Incomplete or illegible forms will not be processed

Purpose: Allow BBJP/OIMA patients the opportunity to receive detailed information regarding their individual healthcare treatment, insurance, billing or other information relevant to their relationship with OIMA.

_____ _____ _____

Patient Last Name (Print) **Patient First Name (Print)** **Date of Birth**

MRN # (office use only):_____

Authorization to Leave Detailed Medical Telephone Messages

Including Voicemail, In-Person, or Other Authorized Forms of Communication

This document authorizes BBJP/OIMA the right to leave detailed medical messages related to specific medical information regarding test results, patient instructions, follow-up care descriptions, medication refill status, referrals or billing and insurance information.

Restrictions (if applicable):_____

I hereby authorize BBJP/OIMA staff, physicians, and representatives to leave detailed medical messages at the following telephone numbers:

*Telephone #1: _____ * Telephone #2:_____

Conditions of Authorization:

1. **I understand that authorization may be granted only to individuals age 18 or over.**
2. **I understand that authorization does not include obtaining copies of electronic or written medical records.**
3. **I confirm that OIMA has explained the limitation and restrictions that apply to this process.**
4. **I understand that detailed messages may not be left with me despite my authorization if determined to be in my best interest.**
5. **I understand that I am fully responsible for reporting changes to the phone numbers that I have provided.**
6. **I understand that authorization is effective on date of signature and does NOT expire until I revoke this authorization in writing.**
7. **I understand that this written authorization may be revoked at any time by writing the Privacy Officer at OIMA.**

My signature below represents my voluntary request to make the above assignments and my full legal authority to do so.

_____ _____ _____

Patient's *Printed* Name **Patient's Authorized *Signature*** **Date of Signature**

Bellevue Bone and Joint Privacy Act Notice

Posted in waiting room. Copies available upon request.

Do you give our office permission to leave a message or discuss your medical information with someone other than yourself? YES NO

If yes, please provide their names, relationship and phone numbers.

Name_____ Relationship_____ Ph _____

Name_____ Relationship_____ Ph _____

Do you give our office permission to leave a message on a home recorder?
YES NO

By signing below, my signature acknowledges that I understand the Privacy Act and HIPPA law.

Date_____ Patient/Guardian_____

OVERLAKE INTERNAL MEDICINE ASSOCIATES, P.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND/OR DISCLOSED AND YOUR RIGHTS RELATED TO USE AND/OR DISCLOSURE. PLEASE REVIEW IT CAREFULLY.

We consider your personal health information to be very sensitive and maintaining the privacy of this information is important to us. Applicable federal and state laws require us to maintain the privacy of your protected health information (PHI). We will not use or disclose your health information to others without your authorization, except as described in this Notice or as required by law.

Please contact our Privacy Officer at (425) 454-5046, if you have any questions about this Notice.

Protected Health Information Defined

PHI is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

Uses and Disclosures Permissible Without Your Written Authorization

Under the law, we may use and disclose PHI without your written authorization under certain circumstances. The examples provided are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

- **Treatment.** We may use and disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service. As another example, we may contact you to remind you about appointments.
- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **Health Care Operations.** We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, or licensing. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We may use or disclose your information to conduct or arrange for services, including medical quality review by your health plan, accounting, legal, risk management, and insurance services and audit functions, including fraud and abuse detection and compliance programs.

- **Required or Permitted by Law.** We must make any disclosure required by state, federal or local law.

- **Minors.** We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

- **Business Associates.** We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to provide transcription or billing services. All of our business associates must agree, in writing, to safeguard your health information, as a matter of contract with us.

- **Military, Veteran and Department of State.** We may disclose PHI to the military authorities of U.S. and foreign military personnel. For example, the law may require us to provide information necessary to a military mission.

- **Workplace Injury or Illness.** Washington State law requires the disclosure of PHI to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We may also disclose PHI for work-related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.

- **Research.** We may use or disclose PHI to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in the research project, as long as they do not remove or take a copy of, PHI.

- **Organ Procurement Organizations.** Consistent with applicable law, we may disclose PHI to organ procurement organizations (tissue donation and transplant) or persons who obtain, store or transplant organs.

- **Public Health Risks and Safety.** We may disclose PHI to public health or legal authorities. Examples include, disclosure to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; to prevent or control disease, injury or disability; to report vital statistics such as births and deaths; to report suspected abuse or neglect to public authorities; to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.

- **Notification of Family and Others.** *Unless you object,* we may disclose to a family member, friend or other person(s) you identify, PHI that directly relates to that person's involvement in your health care. If you are present, then prior to disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up medications, medical supplies, or other similar health related requests.

- **Lawsuits and Disputes.** We are permitted to disclose PHI in the course of judicial/administrative proceedings at your request or as directed by subpoena or other court order. We may also use or disclose PHI to defend ourselves in the event of a lawsuit.

- **Law Enforcement.** We may disclose PHI to law enforcement officials as required by law or when we receive a warrant, subpoena, court order or other legal request.

- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose PHI to a coroner, medical examiner or funeral director consistent with applicable law to allow them to carry out their duties.

- **Correctional Institutions.** If you are in jail or prison, we may disclose your PHI as necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or the safety and security of the correctional institution.

- **Disaster Relief.** *Unless you can and do object*, we may disclose your PHI to disaster relief agencies that seek this information to coordinate your care or provide notification to family or others of your location or condition.

- **National Security.** We are permitted to release PHI to authorized federal officials for national security purposes that are authorized by law.

Other Uses and Disclosures Which Require Your Written Authorization

Certain uses and disclosures of your PHI require your written authorization. They are:

- **Psychotherapy Notes.** If we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures.

- **Marketing Communications.** We must also obtain your written authorization ("Your Marketing Authorization") prior to using PHI to send you any marketing materials. (We may, however, provide you with marketing materials in a face-to-face encounter, without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

- **Sale of Health Information.** Disclosures that constitute a sale of your PHI require your authorization.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may cancel your authorizations for these uses and disclosures of your PHI by submitting a written revocation. Your revocation will not affect information that was already released prior to the time your revocation was received.

Some types of information have greater protection under Washington State or federal laws. The above disclosure practices don't necessarily apply to these types of information, which include information about sexually transmitted diseases, drug and alcohol abuse treatment records, genetic information, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information.

Your Rights Regarding Your Protected Health Information

- **Right to Inspect and Copy.** You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. You may make

this request in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you requested records.

- **Right to Alternative Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication, such as electronic or to receive it at another location.

- **Right to Notice of a Breach.** You have the right to be notified if we become aware of a breach of your unsecured PHI.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on PHI we use or disclose for treatment, payment or health care operations. We are not required to grant the request unless the request is to restrict disclosure of your PHI to a health plan for payment or health care operations and the PHI is about an item or service for which you have paid in-full, directly. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. Your request must state the specific restriction(s) requested and to whom you want the restriction to apply. We are not required to agree to any such restriction you may request.
- **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations. This accounting will be made available once in any 12-month period, for free. For additional requests within the same period, we may charge you a reasonable fee for providing the accounting.

- **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. Your request, our denial, if applicable, and your statement of disagreement, if applicable will be stored in your medical records and included with any medical records release.
- **Right to Obtain Notice.** You have the right to obtain a paper copy of the most current version of this Notice of Privacy Practices.

To Ask for Help or Make a Complaint

If you have a question, want more information, want to report a problem or file a complaint you may contact our Privacy Officer at 1407 116th Avenue NE, Suite 200 Bellevue, WA 98004 or by calling (425) 454-5046. You may also file a written complaint with the Department of Health and Human Services Office for Civil Rights (OCR). We will not retaliate against you if you file a complaint with the OCR or our office.

Effective Date and Changes to This Notice

This Notice is effective on September 1, 2013. We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. This Notice is available on our website; www.oima.org. You may also obtain any revised Notice by contacting the Privacy Officer at (425) 454-5046.

OVERLAKE INTERNAL MEDICINE ASSOCIATES
FINANCIAL POLICY

Welcome to our practice. Our goal is to provide the best care possible to you and your family. To help answer questions you may have, we have outlined our financial policies below. Please feel free to discuss these with us at any time if you have additional questions.

INSURANCE

As a courtesy to our patients, we bill the following insurance companies: Premera, Regence, Medicare, Labor and Industries, and many others. Medicaid patients must present a coupon for each visit. Please ask at the front desk for other insurance we might bill. You are responsible for payment of all Motor Vehicle Accident claims at the time of service.

We are pleased to be able to bill your secondary insurance for you with the information you provide at the time of service. You are responsible for following up to be sure the balance is paid by your secondary insurance or yourself in a timely manner.

CREDIT POLICY

If you have no insurance, you will be asked to pay at the time of service unless arrangements have been made in advance with the Patient Account Manager.

If your insurance company requires a co-pay, it must be paid at the time of service. Please do not ask us to bill you for this amount.

Payment of private balances must be made within 30 days of receipt of monthly statements. We understand that financial problems do arise from time to time. Please let us know if you need to arrange a payment plan. We ask that you notify us while your charges are current.

If a check or bankcard payment is dishonored by your bank for any reason, an additional $25.00 handling fee will be assessed to your account.

REFERRAL AUTHORIZATIONS

If you belong to a managed care plan and need written referrals to see a specialist, we ask that you make certain we have the referral in hand at least three (3) days prior to your scheduled appointment. If no referral is received, you will be asked to pay for the visit at the time of service or reschedule your appointment.

FAILURE TO KEEP APPOINTMENTS

If you fail to keep a scheduled appointment without providing 24-hour notification, you may incur a fee. This charge will be applied to your account and will not be billed to insurance.