The Doctors' Clinic

Duncan Lahtinen, D.O.
Paul Piper, M.D.
Rebecca Johnson, PA-C
Joe Campbell, PA-C
Zachary Stiles, PA-C
Cody Solders, PA-C

220 E. Rowan, Ste 300 ♦ Spokane, WA 99207 ♦ Phone: (509) 489-3554 ♦ Fax: (509) 489-3558

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITIES

PATIENT INFORMATION Today's Date: ___/____/____

Patient Name: _____/_____/_____
Last First MI

Home Phone:(_____)_____ Cell Phone:(_____)_____

Mailing Address: _____
Street City State Zip

Email Address: _____

DOB:_____/____/_____ Age: ____ M F SS# _____- ___- _____ M S D W Other

Ethnicity: Hispanic/Latino Yes No

Race: Asian White Black American Indian/Alaska Native Undetermined
Native Hawaiian/Pacific Islander Multi-racial

Spouse's Name: _____ Spouse's Employer:_____

Person to Notify in an Emergency: _____ Phone:(_____) _____

Is illness/injury work related? Y N Date of Injury: _____ Claim #_____
Is illness/Injury the result of a MVA? Y N Date of Inury: _____ Claim #_____

INSURANCE INFORMATION

Primary Insurance:_____ Subscriber#:_____ Group #_____
Subscriber's Name: _____ SS#_____ DOB:____/____/_____
Address: _____ Phone: (___)_____
City State Zip
Employer Name:_____
Address City State Zip
Employer Phone:(____)_____

Secondary Insurance: _____ Subscriber#_____ Group #_____
Subscriber's Name: _____ SS#_____ DOB:____/____/_____
Employer Name:_____
Address City State Zip

OFFICE PAYMENT POLICY:
It is our policy to require payment of all office charges at the time they are given. All accounts are expected to be paid in full within 90 days, unless other arrangements have been made. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including but not limited to reasonable attorney fees.

Name of person accepting financial responsibility: _____
Signature: _____

THE DOCTORS' CLINIC APPRECIATES THE OPPORTUNITY OF SERVING YOU. WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

CONSENT FOR TREATMENT AND ACKNOWLEDGEMENT OF RECIEPT OF NOTICE

OFFICE PAYMENT POLICY:
It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts are expected to be paid in full within 90 days, unless other arrangements have been made. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, including but not limited to a reasonable attorney fee.

INSURANCE POLICY:
Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you, we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment, and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
I authorize The Doctor's Clinic to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostics, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for the release of the information.

ASSIGNMENT OF BENEFITS:
I hereby assign all benefits for services by The Doctor's Clinic and include major medical benefits to which I am entitled including Medicare, private insurance, and any other heath plan and I ask that The Doctor's Clinic furnish all requested medical information of the person or entity named above. I understand that my records may contain information regarding the diagnosis and treatment of HIV(Aids virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. (Statement required by law.)

The assignment will remain in effect until revoked by in writing. A photocopy of this assignment is to be considered as an original document. I hereby authorize said assignee to release all information necessary to secure the payment. I understand that I am financially responsible to the provider for charges not covered by my benefit plan.

PRACTICE APPOINTMENT POLICY
The Clinic requires that appointments be cancelled 24 hours in advance. In the event that a patient fails to cancel or no show three appointments without giving a 24 hour notice of cancellation, the patient can be discharged from the practice.

Printed Name: _____Signature: _____DOB:____/___/___

Patient Name if different then above: _____ Relationship: _____

Employee Initials: _____ Date: ____/_____/_____

I_____, give the The Doctors' Clinic the right to release my health information to the following recipients.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

The Doctors' Clinic

Duncan Lahtinen, D.O.
Paul Piper, M.D.
Rebecca Johnson, PA-C
Joe Campbell, PA-C
Zachary Stiles, PA-C
Cody Solders, PA-C

◆ 220 E. Rowan Suite #300 ◆ Spokane, WA 99207 ◆ Phone (509)489-3554 ◆ Fax (509)489-3558

Today's Date: _____

Name: _____ Date of Birth: _____

Age: _____ Sex: ☐ Male ☐ Female

Why have you come to see the doctor today? _____

YOUR PAST MEDICAL HISTORY

(Check all that Apply):

	Yr Diagnosed		Yr Diagnosed
☐ Heart Disease	_____	☐ Peptic Ulcer	_____
☐ Stroke	_____	☐ Gastrointestinal Disorder	_____
☐ High Blood Pressure	_____	☐ Head Injury, Seizures	_____
☐ Rheumatic Fever	_____	☐ Migraines	_____
☐ High Cholesterol levels	_____	☐ Mental Illness	_____
☐ Diabetes	_____	☐ Colon Disorder	_____
☐ Kidney Disease	_____	☐ Liver, Hepatitis	_____
☐ Thyroid or Glandular	_____	☐ Sexually Transmitted Disease (HIV, Gonorrhea, Etc)	_____
☐ Asthma/Lung	_____		
☐ Cancer	_____	☐ Other: _____	
☐ Back or Spine Disorder	_____	☐ Other: _____	

GYN (WOMEN ONLY)

Age Menses began: _____ Date of Last Menstrual Cycle: _____ Birth Control Method using now: _____

Total # Pregnancies: _____ Full term pregnancies: _____ Living children: _____ Miscarriages: _____ Abortions: _____

Date of last Pap Smear: _____ Ever abnormal Pap? _____ Date of last mammogram? _____

Do you perform regular monthly self breast exams? _____

VACCINES & CHILDHOOD DISEASES: (Please check all that you have had): ☐ Childhood vaccines

☐ Pneumococcal (pneumonia) vaccine ☐ Hepatitis B vaccine ☐ Tetanus (most recent year): _____

☐ Chickenpox (varicella): ☐ Disease ☐ Vaccine ☐ Other: _____

LIST ALL HOSPITALIZATIONS, SURGERIES OR SERIOUS ILLNESS AND GIVE DATES

TYPE	YEAR	TYPE	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REGULAR MEDICATIONS (include vitamins, over the counter, birth control, herbal meds)

DRUG/DRUG STRENGTH/FREQUENCY

(Example: Tagamet, 400 mg, one 2 times a day)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Allergies/reactions to medications, food, latex, etc: _____ ☐ None

NAME: _____ DATE: _____

FAMILY HISTORY

	Age	Medical Problems (List) and Cause of Death if Deceased	Deceased?
Father	_____	_____	☐ @ age _____
Mother	_____	_____	☐ @ age _____
Brother	_____	_____	☐ @ age _____
Brother	_____	_____	☐ @ age _____
Sister	_____	_____	☐ @ age _____
Sister	_____	_____	☐ @ age _____
Children	_____	_____	☐ @ age _____
	_____	_____	☐ @ age _____

Has any member <u>of your family</u> had (check all that apply):

☐ Diabetes	☐ Sickle Cell Anemia	☐ Heart Disease
☐ Cancer	☐ Glaucoma	☐ High Cholesterol
☐ Rheumatoid Arthritis	☐ Migraine	☐ Asthma / Lung Disease
☐ Stomach Ulcer	☐ Inheritable Disorder	☐ Tuberculosis
☐ Stroke	☐ Mental Illness	☐ Blood Disease
☐ High Blood Pressure	☐ Colon Disease	☐ Thyroid Disease
☐ Epilepsy	☐ Alcohol / Drug Abuse	☐ Osteoporosis
☐ Gout	☐ Kidney Disease	☐ Hepatitis

Please explain any checked above: _____

SOCIAL HISTORY

What is your occupation? _____

Marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

HIV/Hepatitis risk factors: (check below) – or ☐ check here if you do not wish to comment

☐ Tattoos ☐ Homosexual contact ☐ IV drug use ☐ Multiple sexual partners ☐ Blood Transfusions

Tobacco Use History (Circle): Never Smoke(d) Dip/Chew(ed)

If current use: (Packs/day: _____ How many years? _____) Motivated to quit? Y N

If Previous use: (Quit when? _____ Smoked/Dipped how many years? _____)

Alcohol Use: (Circle) ☐ No ☐ Yes How many drinks/week? _____

Drug use: (Circle) ☐ No ☐ Yes Explain: _____

Diet: ☐ Good (low cal, low fat, high fiber) ☐ Average ☐ They know me by name at McDonalds

How many caffeinated drinks/day? _____

Exposure to toxic chemicals: _____

Foreign travel in the past 6 months (Where?): _____

Exercise Routine (what, how much & how often)? _____

Major Changes, stresses: _____

Have you signed for organ donation? _____

Do you have a living will? _____ (If not, please ask if you would like us to provide you with one).

The above is complete and true to the best of my knowledge.

**** X_____ _____ ***

PATIENT'S SIGNATURE DATE

Sixteen Americans die each and every day because there aren't enough available organs to save their lives. ***Please donate.***

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Doctors' Clinic

Duncan W. Lahtinen, DO
Rebecca Johnson, PA-C
Zachary Stiles, PA-C
Paul E. Piper, MD
Joe Campbell, PA-C
Cody Solders, PA-C

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (MI) (Maiden)

Date of Birth: / / Social Security# ____ ___ _____ Phone#( ) -

Information to be released from:	Information to be sent to:
Name:	Name: **The Doctors' Clinic**
Phone: ( ) Fax: ( )	Phone: **509-489-3554** Fax: **509-489-3558**
Address:	Address: **220 E. Rowan, Ste 300**
City/State: ZIP:	City/State: **Spokane, WA** Zip: **99207**

Information to be released:

☐ The last two years of medical records (To include: chart notes, lab reports, x-ray results and special tests).

☐ Pertinent information (as specified above) during the following dates:
From: _____ To: _____

☐ Other specific information:

Patient Authorization

I understand that my records may contain health information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released and I understand that once the health information I have authorized to be disclosed reaches the noted recipient, the person or organization my re-disclose it, at which time it may no longer be protected under Privacy laws.

I have the right to revoke this authorization by sending a notice stopping this authorization to the releasing address above. The authorization will stop on the date my request is received.

I understand that I am signing this authorization voluntarily and that treatment, payment or eligibility for my benefits will not be affected if I do not sign this authorization. **(Request will not be processed without signature and date.)**

I understand I have the right to receive a copy of this authorization.

Signature: _____ Date: _____/_____/_____
(Patient, Guardian or Authorized Representative) (Not valid after 1 year)