Mt. Shuksan Family
Medicine and Dermatology

PCP:
Preferred Name:
Pronouns:
Occupation:

New Patient Intake Form

Name *(Last, First, MI* **:** M F Legal sex:	**DOB:**
Marital status: Single Partnered Married Separated Divorced Widowed	
Address:	
Phone Number:	**Email:**
Emergency Contact:	**Emergency Phone Number:**
Insurance:	**Insurance ID:**
Group:	**SSN:**
Preferred Pharmacy:	**Pharmacy Phone Number:**
I give my consent to receive billing statements via email/text ☐yes ☐no	**My invoice preference is: text email mail**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The practice has the right to email any major operation changes, including but not limited to, location and provider updates.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a detailed message on your contact number with personal health information? YES NO

If YES, please name the members allowed:

This consent was signed by (printed legal name):_____

Signature: _____ Date: _____

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Patient Financial Policy

You are responsible for having your current insurance card and copayment at every visit.

Copayments will be required upon check in. Failure to provide copayment may result in a canceled appointment. If we must bill you for a copayment for any reason, a $10.00 processing fee will be added.

Due to increasing Medicare requirements and restrictions, our clinic can no longer accept new patients with Medicare as their primary or secondary insurance. If you begin care with our clinic after August 1, 2018 and later transition to Medicare as either your primary or secondary insurance, we will be unable to continue your care due to Medicare policies. Please be aware that Medicare may no longer pay for routine labs. It is the patient's responsibility to confirm this prior to completing any outside lab test(s).

The patient's insurance company will be billed if the correct information is given, and insurance payments are current. If insurance is not valid at the time medical services are provided, the patient is responsible for cash payments. The patient will authorize payment from their insurance company directly to MSFMD. The person responsible for payment agrees that all services not coverage under insurance payment will become their responsibility and payment will be made to MSFMD.

Payments not received within thirty days of invoice will be considered delinquent and you will be contacted by our billing department for payment in full or to make arrangements.

MSFMD will promptly process and bill your medical services through insurance. We expect you to promptly pay your portion of your bill. If we have to send out more than one statement for patients with remaining balances unpaid, we will add a service charge of $10.00 for every additional statement we mail out. To avoid additional fees, please promptly pay our bill by calling our billing department at (360) 734-3378.

Patients that are past due with no response to our billed invoices must contact our billing department to coordinate payments or if your account is past 90 days overdue you will be submitted to a collection agency.

We reserve the right to hold medication requests and patient referrals until payment has been made or a payment arrangement is on file with our billing department.

No shows and cancellations with less than 48-hour notice will result in an $80.00 fee. Cancellations called in after 5pm on Friday or during the weekend for Monday appointments will incur a cancellation fee. After three no show appointments, we maintain the right to discharge the patient from the practice.

As a patient of MSFMD we offer an on-call provider for urgent needs of current patients only. Nonurgent matters will be assessed, and a $40.00 fee may apply.

Cash payments will need to be paid in full for all services provided on the date of service. No exceptions.

NSF checks and returned funds will be charged a $35.00 fee and balance will be due in full with a payment of cash or credit.

MSFMD reserves the right to change the term/fees without notice.

By signing below, I certify:
The personal information I provided is true and correct.
I have read, understand, and agree with the financial policies and terms outlined above.
I understand that it is a crime to falsify information or withhold necessary information, punishable by law. I have also been given a copy of the Privacy Policy and I understand and accept it.

Printed legal name:_____

Signature: _____ Date: _____

Please list your current medical concerns / reason for today's visit: _____

_____

_____

MEDICATIONS: List any medicine you take on a regular basis (including over the counter, herbals, inhalers & vitamins):		
Name of medication or supplement	*Dosage*	*Frequency*

ALLERGIES: To medications, food, environmental	
Name of medication or supplement:	*Reaction you had*:

LIFESTYLE AND HABITS: ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	Sedentary (No exercise)				
	Mild exercise (ie, climb stairs, walk 3 blocks, golf)				
	Occasional vigorous exercise (ie, work or recreation, less than 4x/week for 30 min)				
	Regular vigorous exercise (ie, work or recreation 4x/week for at least 30 min)				
Alcohol	Do you drink alcohol?			YES	NO
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			YES	NO
	Have you considered stopping?			YES	NO
	Have you ever experienced blackouts?			YES	NO
	Are you prone to 'binge' drinking?			YES	NO
Tobacco	Do you use tobacco?			YES	NO
	Cigarettes - #pks/day:	Chew - #of times/day	Vape - #/day	Cigars - #/day	
	# of years	or year quit			
Drugs	Do you currently use recreational or street drugs?			YES	NO
	Have you ever given yourself street drugs with a needle?			YES	NO
Sex	Are you sexually active?			YES	NO
	If yes, are you trying for pregnancy?			YES	NO
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			YES	NO
Sleep	Do you have trouble sleeping?			YES	NO
Diet	Do you have problems eating or your appetite?			YES	NO
	Vegetarian Vegan Low-Carb Paleo Keto Atkins Zone Low-Fat N/A Other:				
Occupation					
Relationship	Single Married Life Partner Separated Divorced Widowed Other				

FAMILY HEALTH HISTORY:	SIGNIFICANT HEALTH PROBLEMS
Mother Age:	
MGM Age:	
MGF Age:	
Father Age:	
PGM Age:	
PGF Age:	
# Male Siblings:	
# Female Siblings:	
# of Male Children:	
# of Female Children:	

Is stress a major problem for you?	YES	NO
Do you feel depressed?	YES	NO
Do you panic when stressed?	YES	NO
Do you cry frequently?	YES	NO
Have you ever attempted suicide?	YES	NO
Have you ever seriously thought about hurting yourself?	YES	NO
Have you ever been to a counselor?	YES	NO

PAST MEDICAL HISTORY: Please list the year and description of any surgeries or hospitalizations

WOMEN'S HEALTH QUESTIONNAIRE	
Date of last menstruation:	Other concerns:
Age of first menstruation:	
# of pregnancies:	# of births:
# of miscarriages:	# of terminations:
Date of last pap smear:	
IMMUNIZATIONS:	
MMR Date:	Gardasil Date:
Shingles Date:	Tetanus Date:
Hep A Part 1 Date:	Hep A Part 2 Date:
Hep B Part 1 Date:	Hep B Part 2 Date: