JAMISON
FAMILY MEDICINE
COMPLETE HEALTH & WELLNESS

Receipt of Notice of Privacy Practices Acknowledgment

You have received a copy of **Jamison Family Medicine's** Notice of Privacy Practices. Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

After you complete the form, please give it to the person helping you with your visit.

Thank you for your cooperation in completing this federally required form.

By signature below, I acknowledge receipt of the Notice of Privacy Practices.

Signature (Patient or legally authorized individual) Date Time

Printed Name of the patient

Relationship if signed on behalf (Parent, legal guardian,personal representative)

This form will be retained in your medical record.

Patient Information (Please print)

*Patient- Last Name First Middle				*Male Female	Marital Status S M D Sep
*Mailing Address:	City	State	Zip	*Home Phone #	
*Social Security Number	Age	DOB		Cell Phone #	
Employer	Occupation		Race	Work Phone #	
Spouse's Name	Spouse's Employer			Email Address	
Children's Name	Age	Children's Name		Age	
Children's Name	Age	Children's Name		Age	
*Emergency Contact		Relationship		*Phone #	
Referred by					

Financial Responsibility (This is who billing statements are addressed to)

*Person Financially Responsible	*Phone		*DOB	*Relationship
Address	City	State	Zip	*Social Security Number
*Employer	Address			*Gender

Medical Insurance

*Name of Primary Insurance	*Policy Holder Name	*DOB	*Identification Number
*Relationship to Patient	*Policy Holder SSN	Group Name	Group Number
*Policy Holder Address if different than patient's			Policy Holder Phone #
Name of Secondary Insurance	Policy Holder Name	DOB	Identification Number
Relationship to Patient	Policy Holder SSN	Group Name	Group Number
Policy Holder Address if different than patient's			Policy Holder Phone #

I hereby give permission to receive treatment and tests deemed necessary by the doctor. I also accept financial responsibility for charges if a service is denied by my insurance. I understand, upon request, medical records could be sent to my insurance company.		
*Signature	Relationship if Minor	Date

*= MANDATORY FIELD

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Jamison Family Medicine Billing and Financial Responsibility Policy

Jamison Family Medicine (JFM) participates with many insurance plans. If your insurance plan is one that we participate with, our billing team will submit a claim for services to your insurance company. Based on your coverage you may be responsible for some (or all) services you receive as they may be non-covered or considered not medically necessary. JFM will bill your insurance for all services rendered; it is the responsibility of the patient to know your insurance plan. JFM will verify eligibility for the information supplied. If your insurance is not eligible we will make good effort to contact you before your appointment to let you know. If no insurance coverage can be verified, you will be responsible to pay for services at time of visit.

Responsibility of JFM:

- To bill all claims to your insurance carrier(s) in a timely manner on your behalf
- To assist you with resolving claims issues regarding payments

Responsibility of Patient

- To pay your copay, coinsurance, or deductible at time of service
- To provide accurate insurance information at time of visit so JFM can submit your claim correctly
- To pay any remaining account balance after insurance has paid within 60 days of receipt of your first statement

Insurance:

Jamison Family Medicine accepts most insurance plans with the most common insurance plans listed below. Please contact our office if you have questions regarding your insurance plan.

- Kaiser Permanente
- Asuris
- First Choice Health Network
- Premera
- Aetna
- United Healthcare/ AARP
- Uniform/Regence
- Molina
- Medicare
- Cigna
- Amerigroup

Payment:

Jamison Family Medicine accepts cash, credit card, and personal checks as form of payment. If two or more checks are returned from your bank, you will be required to use another form of payment and will be charged $425.00 for each returned check.

Self-Pay Patients:

This status is reserved for patients that do not have any medical insurance coverage. Jamison Family Medicine has a flat rate schedule for patients with no insurance. Payment for self-pay patients is due at time services are rendered.

Workers Comp and L&I:

If you are involved in an incident or accident at work that will result in your medical claims being billed to Labor and Industries instead of your medical insurance coverage, please know that all necessary information to bill L&I will be required at time of service. You will be required to fill out the necessary paperwork for L&I. As a courtesy, if your claim is denied or closed, JFM will bill your private insurance.

Third Party:

If you are involved in an accident/incident (MVA, slip and fall, etc.) that will result in your medical bills being paid by an entity other than your medical insurance coverage, please note that all necessary information to bill will be required at time of visit to Jamison Family Medicine. If you would like us to bill a third party payer we will need the following:

- Insurance company name
- Insurance policy holder's name, address and phone number
- Full claim number for the accident
- Claim contact person

If payment is not received within 90 days, Jamison Family Medicine will bill you for the full amount and you will need to provide this information to the Third Party payor for reimbursement.

I acknowledge I have received, read and understand Jamison Family Medicine's billing and financial responsibility policy and that I will comply with these policies.

Signature: _____ Date: _____
Print Name: _____
Phone: _____

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Jeffrey R. Jamison, D.O. * Mark J. Erwin PA-C

Patient Name: _____ **Date of Birth:** _____

New Patient Information

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. All questions contained in this questionnaire are optional and will be kept strictly confidential.

Reason for visit:

_____

_____

_____

_____

_____

Allergies: List anything you are allergic to (medications, food, bee stings, etc.) and how it affects you:

_____

_____

_____

_____

_____

Favorite pharmacy:

_____

Medications: Please list all the medications you are taking including prescribed, over the counter and supplements (make sure to include strength and how often it's taken):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

Past Medical History: Circle any of the following that apply to you:

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobia	HIV or AIDS	Reflux or Ulcers
Diabetes- Insulin	High Cholesterol	Stroke
Diabetes – Non Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

Immunization History: Please indicate Y/N for immunizations you were given and when. If unknown, which facility would have them on file?

Chicken Pox:	Date:	MMR (Measles, Mumps, Rubella):	Date:
Flu Shot:	Date:	Pneumonia:	Date:
Gardasil/HPV:	Date:	Tdap(Tetanus, diphtheria, pertussis):	Date:
Hepatitis A:	Date:	Tetanus:	Date:
Hepatits B:	Date:	Zostavax/Shingles:	Date:
Meningococcus:	Date:	Other:	Date:

(Women Only) Obstetric and Gynecological History:

Last pap smear:		Last mammogram:	
Age of first period:		Number of births:	
Number of pregnancies:		Number of miscarriages:	
Last period/Age of Menopause:		Number of cesarean sections:	
Number of abortions		Current sexual parter:	Male or Female
Do you use condoms?	**Y / N**	Method of birth control:	
Interested in STD screen?	**Y / N**		

(Women Only) Circle any of the following that apply to you:

Bleeding between periods	Heavy Periods	Extreme Menstrual Pain	Vaginal itching, burning or discharge	Waking up in the night to use the restroom
Hot Flashes	Breast lump or nipple discharge	Painful intercourse	Sexually Active	Other

Past Surgical History (Please include year, reason and what hospital and/or doctor if you are able):

_____

_____

_____

_____

_____

Family History: Please place a check in the boxes appropriate for your family history.

Relation	Grandmother (M)	Grandfather (M)	Grandmother (P)	Grandfather (P)	Mother	Father	Brother	Sister	Other

Alive?									
Age									
Alcoholism									
Arthritis									
Depression									
Cancer/type									
Diabetes									
Genetic disease									
Heart disease									
Hypertension									
Osteoporosis									
Stroke									
Other									

Social History: Circle the following that apply to you:

Education	**Marital Status**	**Exercise**	**Caffeine**
○ <8th grade ○ High School ○ 2 Yr college ○ 4 Yr college ○ Post Graduate	○ Married ○ Single ○ Divorced ○ Separated ○ Widowed ○ Domestic Partner	○ No Exercise ○ Occasional Exercise ○ Moderate Exercise ○ High Level Exercise	○ None ○ Occasional ○ Moderate ○ Heavy _____ # of cups per day?

Alcohol	**Tobacco**	**Drugs**
Drink alcohol? Y / N How often? ○ Occasionally ○ < 3 times a week ○ > 3 times a week # of drinks/ week? _____	Do you use tobacco? Y / N If not now, did you ever use tobacco? Y / N ○ Cigarettes _____ pks/day ○ Chew _____/day ○ Cigars _____/day # years used _____ Or years quit_____	Do you currently use recreational or street drugs? Y / N If yes, please list which ones:

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JAMISON FAMILY MEDICINE
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth_____

Home Address_____

City _____ State _____ Zip Code _____

Home Phone _____ Cell _____

I authorize Jamison Family Medicine to leave lab, x-ray results, and appointment information on my home answering system.

PATIENT SIGNATURE _____ DATE _____

I authorize Jamison Family Medicine to release any and all medical information on myself to the below named individuals. This release also applies to any confidential information that might be contained in my medical record.

Individuals who my medical information may be released to:

Name _____Phone: _____

Relationship to Patient: _____

Name _____Phone: _____

Relationship to Patient: _____

Name _____Phone: _____

Relationship to Patient: _____

PATIENT'S SIGNAGURE _____ DATE _____

If a patient has reached his/her fourteenth birthday ONLY the patient may authorize disclosure relating to sexual diseases, birth control, sexual activity, or drug usage.

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Jamison Family Medicine

9631 N Nevada St., Suite 210, Spokane, WA 99218
Phone: (509)319-2430 Fax: 877-568-2402

Authorization for Jamison Family Medicine to Obtain or Disclose My Health Care Information

Jamison Family Medicine Medical Provider: _____

Patient name: _____ Date of birth: _____

I request and authorize Jamison Family Medicine to: ☐ **Obtain From or** ☐ **Release To**

Name_____Address:_____
City: _____ State: _____ Zip Code:_____
Phone:_____Fax:_____

You may use or disclose the following health care information:

☐ All health care information in my medical record (includes 3 year history of records is sent when transferring care).

☐ Health care information in my medical record relating to the following treatment or condition:_____

_____

☐ Health care information the following date(s): _____ thru _____

☐ Other _____

I understand that my medical record may include information on the diagnosis/treatment related to psychiatric, psychological or mental conditions, drug and or alcohol use or abuse, sexually transmitted diseases (STD), acquired immune deficiency syndrome (AIDS), and or HIV status and genetic testing.

Please exclude health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ HIV (AIDS virus)
☐ Psychiatric disorder/mental health
☐ Drug and/or alcohol use
☐ Sexually transmitted diseases

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Change of Provider ☐ Attorney ☐ Other (please specify) _____

If neither of the above is checked, this request will expire in 90 days from the date of signature

My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Jamison Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Ways to revoke this authorization are to write a letter to Jamison Family Medicine. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature **Date**

Printed name if signed on behalf of the patient **Relationship**

**** A fee for the cost of processing this request may be charged***

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Demographic Data Collection

Federal regulations require that we collect the following information. Your answers are voluntary. Thank you for your cooperation.

1. **Do you consider yourself Hispanic or Latino?** Please choose one.

   - ☐ I am Hispanic or Latino
   - ☐ I am not Hispanic or Latino
   - ☐ Undetermined
   - ☐ Decline to answer

2. **What category best describes your race?** Please choose one.

   - ☐ White/ Caucasian
   - ☐ Black/African American
   - ☐ Native American
   - ☐ Asian
   - ☐ Pacific Islander
   - ☐ Unreported
   - ☐ Decline to answer

3. **What language do you prefer when speaking with your doctor?**

   - ☐ English
   - ☐ Spanish
   - ☐ Russian
   - ☐ Other _____

4. **On-line tools coming soon! Do you have an email address you would like to be contacted through?**

   Email: _____

Patient Name: _____
Please Print

Date of Birth: _____