Three Rivers Family Medicine, PSC

Welcome to Our Office

Dear Patient,

Thank you for scheduling an appointment with Three Rivers Family Medicine, PSC. It is our pleasure to welcome you to our practice in advance of your first visit.

You will find some information here that will help familiarize you with our practice. If you have any questions after reading the material, please give the office a call. Enclosed you will find a green colored Health Screening Questionnaire which MUST be completed before your visit, Our Financial Policies, and a Medical Records Release Form. **Please complete any forms prior to your visit and bring them with you to your appointment.**

Please bring with you the following items for each of your visits:

- Insurance ID card
- Picture ID
- Office visit co-pay (we accept cash, checks, and MasterCard or Visa payments). Your co-payment, if required by your health insurance company, is due at time of service.
- For children—please bring a copy of your child's immunization record
- Copies of old medical records, if any. If you do not have copies of your medical records, please complete the Medical Records Release form we have enclosed. Please include previous provider/clinic name, address, phone # and fax number. You may send the completed form to your previous provider/clinic or bring form with you to your appointment and we will send it in for you.

Please arrive 10-15 minutes early to allow time for registration and time to contact your insurance carrier to verify/designate Three Rivers Family Medicine, PSC as your primary care office.

Kindly give 24 hours notice if you are not able to keep your appointment. This will enable you to avoid our $50 "no-show" fee.

For prescription refill requests, please allow 24-48 hours for us to check the records and contact your pharmacy. We usually have these done by the end of the business day (after seeing patients).

We appreciate your selection of our office to provide your medical care and we will work hard to serve your needs.

Sincerely,

Appointment Date & Time: _____

Provider: _____

945 Goethals Drive, Suite 300 Richland, WA 99352
Phone 509-943-3196 Fax 509-946-0455

Financial Policies

Thank you for choosing Three Rivers Family Medicine, PSC for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific
physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of- pocket fees, and coverage limits.

PLEASE KEEP THESE POLICIES FOR FUTURE REFERENCE

Insurance Coverage
Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Our doctors belong to many insurance plans but participation differs by doctor. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. We will help you find out if you have out-of-network benefits and submit a claim to your plan on your behalf. Refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim to your plan.

Address Change
It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments/Co-insurances/Deductibles
You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.

Payments

Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card *(MasterCard or Visa)*. Returned checks are subject to a fee.

Non-Medical Fees

Additional fees may apply to the following:

- Returned Checks
- Completion of disability or other forms
- Copying of medical records

Missed Appointments

We require a 24 hour cancellation notice. If you miss your appointment, or do not cancel with the required notice, additional fees may apply:

- Office Visit: $50
- Second Office Visit $75
- New Patient Visit: $75
- Office Procedure /Surgery $150

Out-of Network Providers

If the doctor is not in your insurance plan, the following apply:
- Full payment is due at the time of service for routine visits.
- Payment expected on the date of service may be an estimate of your total charges.
- You will be quoted an estimated fee before services/procedures are performed.
- A deposit is required prior to the date of service for elective surgeries and procedures.
- After your appointment, we will submit a claim to your plan for services performed.
- Depending on your plan, payment may be sent to you. If you receive this payment, you must reimburse Three Rivers Family Medicine, PSC immediately.

Non-Covered Services

Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.

Non-Medicare Patients. Any service not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds
A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our billing office at (509) 943-9092

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Failure to Pay
If you do not pay your bill, your account will be sent to an outside collection agency. If your account is sent to a collection agency, you need to contact them directly to settle your balances.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications. We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our staff for more details or call our billing office at (509) 943-9092.

Revised 7-24-2012

Three Rivers Family Medicine, PSC

PATIENT INFORMATION

Today's Date: _____

Welcome and thank you for choosing our clinic.

In order to serve you properly, we need the following information. All information is strictly confidential.

Patient's Name (Last, First, MI)		Sex ☐ Male ☐ Female	Birthdate	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	
Address	City	State	Zip Code	Home Phone	Cell Phone
If a minor, parents or legal guardian's name Father	Mother			Legal Guardian	
Name of Employer	Address			Work Phone	
Occupation	Driver's license number			Social Security number	
Insurance #1 name & address				Subscriber name	
Policy number	Group number			Member ID number	
Secondary insurance name & address				Subscriber name	
Policy number	Group number			Member ID number	
Name of Guarantor or Spouse		Birthdate		Social Security number	
Address				Relationship to patient	
Name & address of spouse's employer				Work Phone	
Emergency Contact		Phone number		Relationship	
Pharmacy:					

Race: (Circle One) White Hispanic Black/African American Asian Other

American Indian/Alaska Native Native Hawaiian/Pacific Islander Prefer not to Answer

Ethnicity: (Circle One) Hispanic/Latino Not Hispanic or Latino Prefer not to Answer

Preferred Language: (Circle One) English Spanish Other (specify) _____

Appt Reminder Communication: (Circle One) Phone Text Phone #: Home or Cell

Email Address:

Revised 12/13/2013

Three Rivers Family Medicine, PSC

Patient Authorizations

Assignment of Benefits

I do hereby authorize medical treatment and the release of any medical or other information that will be necessary for either medical care or in processing applications for financial benefit. I also authorize direct payment of surgical/medical benefits to TRFM, PSC for services rendered. I understand that I am financially responsible for any balance that is not covered by my insurance.

Prescription History

We may access prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers to better assist you with your healthcare needs.

Notice of Privacy Practices (HIPAA)

As a patient of TRFM, PSC, you have the following patient rights in regard to your Personal Health Information (PHI):

- The right to authorize the use and disclosure of your PHI
- The right to receive a copy of the practice's Notice of Privacy Practices
- The right to request restrictions on certain uses and disclosures of your PHI
- The right to request restrictions on how the practice communicates PHI to the patient
- The right to request an amendment of your PHI if you feel it is incorrect or incomplete
- The right to inspect and copy your PHI
- The right to an accounting of the disclosures of your PHI
- The right to file a complaint

Copies of all referenced documents are available upon request.

Please read and return this signed form to the receptionist.

X_____**Date:**_____

Patient Name:_____

945 Goethals Drive, Suite 300 Richland, WA 99352
Phone 509-943-3196 Fax 509-946-0455

Three Rivers Family Medicine, PSC

Authorization to Use or Disclose Protected Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

My Authorization: Name (or title) and organization or class of persons: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I. **may use or disclose the following health care information** (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., X-rays, bills)—specify date(s): _____

Uses and Disclosures Requiring Specific Authorization

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV/AIDS
- ☐ Mental Health or Illness
- ☐ Reproductive Care (minors only)
- ☐ Sexually Transmitted Diseases
- ☐ Drug and/or Alcohol Abuse

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 & older), drug &/or alcohol abuse (if age 13 & older), & mental health or illness (if age 13 & older).*

You may disclose this health care information to:

Three Rivers Family Medicine, PSC 945 Goethals Drive, Suite 300 Richland, WA 99352

Phone 509-943-3196 Fax 509-946-0455

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). 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 **TRFM, PSC** 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—a form is available from **TRFM, PSC** or
   - Write a letter to **TRFM, PSC.**

III. **Protection after Disclosure.** I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

_____

Minor patient's signature, if applicable Date Time

Health Screening Questionnaire

(to be completed prior to your first visit to Three Rivers Family Medicine)

Name _____ Birthdate _____

What medications do you take regularly?

(Include prescriptions, vitamins, birth control pills and over the counter medicine)

Medication	Dose	Medication	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Any other Physician's seen regularly: _____

_____

Allergies (Medication or Other) Type of Reaction

1._____ _____

2._____ _____

3._____ _____

Have you ever been told by a doctor that you have the following problems?

Circle all those that apply

High Blood Pressure	High Cholesterol	Asthma/Lung Problems/Emphysema
Diabetes	Thyroid Disease	Depression/Anxiety

Have you ever had the following conditions? Circle all those that apply

Heart Attack	Stroke	Allergies	Heart Disease
Hepatitis/Liver Disease	Anemia	Eye Disease	Alcoholism/Substance Abuse
Headache/Migraine	Seizures	Tuberculosis	Cancer-Type:_____

Other Significant Problems:_____

_____

Are you experiencing any of the following?

Current or Recurrent

General: General health (excellent good fair poor) Recent Weight Change: Lost Gained Intentional

fever chills night sweats fatigue

Skin: rash itching dryness non-healing sores color changes changing moles hair loss

Eyes: glasses/contacts vision loss blurring redness double vision

Ears/nose: decrease hearing ringing in ears ear pain sinus pain nasal discharge congestion
nose bleeds

Mouth/throat: dental problems sore throat hoarseness swallowing problems

Respiratory: cough shortness of breath coughing up blood painful breathing wheezing/asthma

Cardiovascular: chest pain shortness of breath while lying flat swelling in legs leg cramps with exercise

lightheadedness/dizziness rapid heartbeat murmurs

Gastrointestinal: poor appetite heartburn nausea vomiting abdominal pain bloating diarrhea
constipation blood in stool hemorrhoids

Genitourinary: pain with urination frequent urination increased urination at night blood in urine
trouble holding urine

Musculoskeletal: joint pain (hands / elbows / shoulders / hips / knees / feet) joint swelling joint stiffness

back pain history of fractures muscle pain

Hematologic: easy bleeding/bruising prior blood transfusions anemia

swollen lymph nodes

Neurologic: headache/migraines concussions loss of consciousness numbness
dizziness memory loss difficulty walking tremor incoordination muscle weakness

Psychiatric: sadness hopelessness loss of pleasure tearfulness hospitalization
suicidal thoughts or feelings anxiety panic fear of social situations

Sleep: insomnia shift work sleep apnea snoring bed time ( ) awakening time ( )

Social: Any significant family, work or financial stressors? Yes/No Do you feel safe in your home? Yes/No

Female Only: pelvic pain excessive hair growth menstrual problems menopausal concerns

Male Only: prostate problems frequent nighttime urination erectile dysfunction loss of urine control
decreased urine flow

Surgeries: please include dates, surgeon name, location

_____ _____

_____ _____

_____ _____

Hospitalizations and other medical conditions: please include dates

_____

_____

_____

FAMILY MEDICAL HISTORY

Please list family members with significant health problems

Relationship	Living? Age of Death	Yr of Birth/Age	Medical Problems/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____

Siblings Brothers_____ Sisters _____ Health Issues_____

Children Sons_____ Daughters_____ Health Issues_____

Other family health issues:_____

_____

LIFESTYLE

Do you use any kind of tobacco? Yes or No Have you ever used tobacco in the past? Yes or No

Type: Cigarette/Cigar/Pipe E-Cig Chewing

Amount, how many years? _____

Quit date/dates : _____

Sexual History: Are you sexually active? Yes or No

If so, with Men Women or Both

Have you had more than one sexual partner in the last 10 years? Yes or No

Had a sexually transmitted disease? Yes or No Type:_____

Had a blood transfusion before 1985? Yes or No

Ever had an HIV test? Yes or No

Ever had Hepatitis C test? Yes or No

Drugs: Do you or have you ever used illicit drugs? Yes or No

If yes, when and what do you use? _____

Alcohol: Do you drink alcohol? Yes or No

If so, how often and what types?_____

Exercise: Do you have an exercise program? Yes or No

Type:_____Minutes _____ Frequency_____

Living with:_____ Marital Status:_____

Occupation:_____

Age 65 or over:

Do you or your family think you have memory problems? Yes or No

How many times have you fallen in the past six months? _____

Immunizations

Do you know the date of your last : Tetanus Vaccine: Date: _____ Td or Tdap

Pneumonia Vaccine Date: _____

Flu Vaccine Date:_____

Hepatitis B Dates:_____ Hepatitis A Dates:_____

Measles Dates:_____

Ever had Chicken Pox? Yes or No

Tuberculosis (TB) Skin Test? Date: _____Have you had a positive reaction to a TB skin test? Yes or No

Were you treated for this reaction? Yes or No With what and how long? _____

Colon Screening

Ever had screening? Yes or No

Date of last Sigmoidoscopy/Colonoscopy: _____

Where/Doctor:_____

Results: _____

Women Only: Do you examine your breasts each month? Yes or No

Have you noticed any unusual lumps or discharge in your breasts? Yes or No

Have you ever had an abnormal Pap Smear? Yes or No

Have you had an HPV Test? Positive or Negative

Date of last Pap Smear: _____Date of last Mammogram: _____

Have you ever taken hormones? Yes or No

Do you bleed between periods, or since going through menopause? Yes or No

# of pregnancies have you had?_____ Miscarriages _____ Abortions_____

Date of last normal period? _____ Have you had a hysterectomy? Yes or No

Why? _____

Have you ever had a DEXA Scan? (Bone Density study for Osteoporosis? Yes or No

Year:_____ Findings:_____

TR FM Three Rivers Family Medicine, PSC

Consent To Inform- Your Right to Privacy

** Please Print**

We respect your right to privacy regarding your medical information. By filling out the information below, you are giving us permission to share your information with others.

1. _____

PATIENT'S Name: _____ DOB: _____Date:_____

Spouse Full Name:_____

2. _____

We understand you may have concerned family members as well. Please list the names of adults, children, other family members and/or a contact person with whom we may share information, and their relationship to the patient.

Name: _____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

3. _____

Please check all the boxes below for any information regarding your health care that you would like disclosed.

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

☐ All general health information (not including sensitive subjects below)

☐ Other- specify date(s) or conditions:_____

Sensitive Subjects

☐ HIV/AIDS ☐Sexually Transmitted Diseases ☐Mental Health or Illness

☐Drug and/or Alcohol ☐ Reproductive Care (minors only)

4. _____

_____ _____

Signature of patient Date

_____

Relationship or status if signed by anyone other than patient

If there are any changes to be made to this authorization, it is the patient's responsibility to inform TRFM.

THIS AUTHORIZATION WILL EXPIRE YEARLY, UNLESS OTHERWISE REVOKED

TR FM Three Rivers Family Medicine, PSC

Consent to Contact Electronically

We are now able to send you certain information via text message or email. If you wish to receive these text messages or emails we do require your consent. Please read the disclaimer below carefully then complete and sign the bottom of the form. If you choose **NOT** to receive these messages please sign below and you don't need to go any further.

I understand that I am signing this consent form **refusing** any text messages or emails from TRFM.

_____ _____

Name Date

I consent to Three Rivers Family Medicine, PSC contacting me by text message or email for the purposes of health promotion, billing inquires, general letters and appointment reminders.

I acknowledge that appointment reminders by text or email are an additional service and that these may not take place on all occasions, and that the responsibility of attending appointments or canceling them still rests with me.

Text messages and emails are generated using a secure facility. I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number or email changes or if this is no longer the way to communicate with me.

_____ _____

Cell phone # Email Address

_____

Print Name

_____ _____

Sign Name Date