Welcome to Eastside Total Health & Lactation!

Thank you for considering us for your Family Building plans.

Eastside Total Health & Lactation is a private medical practice specializing in serving the WHOLE you. Our providers and staff have many years of experience providing care for the whole family and specializing in the childbearing years. From conception to lactation, we are here to provide a warm and safe environment to grow your family.

Enclosed in your new patient packet, you will find the following forms:

- New Patient Checklist
- Registration forms
- Financial Contract
- Consent for Treatment
- Medical History Intake
- Credit Card Authorization Form
- Family Building Fee Schedule
- Insurance Benefits Questionnaire

You may either download these forms or complete them online at: www.eastsidetotalhealth.com. Please note that the entire New Patient Packet needs to be received completed in our office prior to services starting.

It is highly preferred that you contact our Business Manager, Chelsea Doyle, to discuss the billing and payment process before services begin. You can schedule a phone or in person meeting with her by calling our office at 425.836.6847. She will be able to answer any questions you have regarding how your claims are processed and what you can expect for payment processes.

Your first visit here is consultation only. This visit is designed to establish care here at Eastside Total Health & Lactation and review your medical history so we can best serve you. No procedures are done at your first visit. It is recommended that you obtain or request any previous medical records or labs that are relevant to your family building plans. Collectively, between you and Eastside Total Health & Lactation, your new Family Building plan will begin!

We look forward to working with you. When your New Patient Packet is complete, please contact our office to schedule your first visit!

Sincerely,

Jennifer Jimenez CNM, ARNP
Kristina Chamberlain CNM, ARNP, IBCLC

Family Building New Patient Checklist

Please complete the following steps to be prepared for your first visit at Eastside Total Health & Lactation:

- ☐ Complete the Registration Form
- ☐ Read and Sign the Financial Contract
- ☐ Read and Sign the Consent for Treatment
- ☐ Complete the Medical History Intake
- ☐ If applicable, have previous medical records & labs sent to Eastside Total Health & Lactation
- ☐ Credit Card Authorization Form signed
- ☐ Review the Family Building Fee Schedule
- ☐ Complete the Insurance Benefits Questionnaire by calling your insurance company
- ☐ Schedule a Financial Consultation meeting with our Business Manager (optional but highly recommended)
- ☐ Schedule your first visit with Jennifer Jimenez CNM, ARNP
- ☐ Bring your insurance card and ID and please arrive 10 minutes early to your first visit

Thank you! We look forward to working with you.

Eastside Total Health & Lactation

Name:			Today's Date:
Birthdate:			
Street Address:			City, State, Zip:
Cell Phone:	Home:		Work:
Occupation:			Employer:
Email:			PCP name: Phone:
How did you hear about ETH&L?			
INSURANCE INFORMATION Please give your insurance card and photo ID to the receptionist.			
Primary Insurance:			
Insurance ID #:			Group #:
Co-Pay: $			
Subscriber's Name			Subscriber's Birth Date:
Subscriber's SS #:			Relationship to Subscriber:
Secondary Insurance:			Subscriber Name:
Group #:			Policy #:
IN CASE OF EMERGENCY			
Name: Cell Phone:	Relationship: Work Phone:		Can we leave a message with this person? Yes or No
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION			
May we call you at home? Yes No			May we leave a message at your home? Yes No
May we leave a message on your cell? Yes No			May we call you at work? Yes No
I acknowledge& agree to adhere to the Notice of Privacy Practices as required by federal & state guidelines. I understand I may request/review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.			
Patient/Guardian Signature:			Date:
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INORMATION			
I have completed this form and certify that I am the patient or legal guardian of patient. I authorize the providers of Eastside Total Health & Lactation (ETH&L) to provide medical care and treatment for me. I authorize payments of benefits to be made directly to ETH&L. I understand that as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed. Failure to pay in 30 days could result in a $10 late fee.			
Patient/Guardian Signature:			Date:

Financial Contract & Office Policies

As a patient of the Eastside Total Health & Lactation, and by signing below, I agree to the financial responsibilities for any fees not covered by my insurance carrier and to the office policies listed below. Any outstanding fees must be paid at time of service. I also understand that it is my responsibility to confirm insurance coverage before my scheduled appointment.

Fees, Third Party Billing & Co-pay Policy: In addition to the policy stated above, inability to pay your co-pay at the time of service will incur a $10 service charge. If you have any questions regarding your insurance coverage or fees, you can contact your insurance directly, or contact our Business Manager- Chelsea Doyle at 425.836.6847. If you are self-pay, you may contact the office for a fee schedule.

Authorization for billing E-statement: I authorize ETH&L to send me billing statements via email.
Patient initials: _________

Patient Declines: ◯ **I do NOT wish to receive my billing statement electronically.**

Insufficient Funds Policy: If a check does not clear due to insufficient funds, a $25 fee will be added to the outstanding balance.

Late Policy: ETH&L respects your time, and we ask that you respect ours. Appointments are not double-booked and do not intentionally run over. If you are more than 10 minutes late for your appointment, you may be seen for any time remaining or asked to reschedule. If you expect to be late, please let us know as soon as possible by calling the office at 425-836-6847.

No Shows/Cancellations Policy: If you need to cancel an appointment, please do so within 24-48 business hours of the appointment time. Business hours do not include weekend or holidays. Appointments canceled with less than 24 hours notice will incur a $50 fee. Three unexplained no-shows will result in dismissal from the practice.

Phone & Email Consults: Brief questions can be answered over the phone or email at no charge. Complex concerns will not be answered this way; it is not good practice and can result in less optimal care. If you have a more complex concern, you will be asked to make an appointment, or you will be charged $50 for a more involved phone/email consult.

____ ____
Name of Patient (Print) *Signature of Patient*

____
Date

ETH&L's Consent for Treatment and Acknowledgment of Receipt of Notice of Health Information Privacy Practices and Consent to Disclosures

Name of Patient: ___________________________________ Today's Date: ____________________

Date of Birth: _____________________________________ Phone: _________________________

As a patient of the Eastside Total Health & Lactation and by signing below:

I hereby authorize Eastside Total Health & Lactation to provide care, perform general diagnostic procedures and exams as necessary to facilitate my diagnosis and treatment.

I understand that I may ask questions regarding my diagnosis, treatment, fees, and insurance coverage, or any other aspect of my care before signing this form. With this knowledge, I voluntarily consent to the policies and procedures of Eastside Total Health & Lactation.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during visits. I understand that free interpretive services may not be available and that I may be referred to another health care facility to provide the services necessary for my care.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice to obtain these services and that I may change my mind about receiving medical care from ETH&L at any time.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive test results to the public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by a representative or me, or otherwise permitted or required by law.

I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

I hereby certify that I have reviewed the *Notice of Privacy Practices* for Eastside Total Health & Lactation that is available on the website**.** I understand that if I have objections or concerns with this policy, I must notify ETH&L.

____ *Today's Date* _________________

Patient Name (printed)

____

Signature by Patient/Parent/Guardian

Legal Name* : Birth Date: Preferred Name:	Allergies: e-mail address:	
Legal Sex (please circle one)* Female Male **While ETH recognizes a number of genders/sexes; many insurance companies and legal entities unfortunately, do not. Please be aware that the name and sex you have listed on your insurance must be used on the documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*	Age:	Preferred pronouns:
Reason for today's Visit:	Your Primary Care Provider:	
Marital Status:	Your occupation:	

Menstrual History

Age when period first started: First day of last period:
# of days you bleed: # of days between periods:
Any problems with period? Y N Amount of bleeding: Heavy Medium Light

Sexual History

I have sex with (circle one): Men Women Both Bi-Sexual partners Trans/Queergender partners Not active
Age at first intercourse: Date of last pap smear? Last abnormal pap:
I have had or my partner has had a new partner in the last year: Yes No Not active
Do you have any bleeding or pain with sexual activity? Yes No
How do you protect yourself from sexual transmitted infections?

Pregnancy History

# of full term pregnancies: # of premature pregnancies: # of vaginal births:
# of c-sections: # of miscarriages: # of abortions: # of ectopic preg.:
# of living children: Ages of children: # of children placed for adoption:
# of children adopted:

Contraceptive History

Current method of birth control: Problems with it? Yes No
Other methods used in past: Want to changing methods? Yes No

Menopause and Beyond

Age you stopped having periods: Problems or concerns? Yes No
Taking hormone therapy (HT)? Yes No

Gynecological/Medical/Surgical History- check if you have or have had

☐ Abnormal uterine bleeding	☐Pelvic Pain	☐Abnormal pap smear/treatment
☐Fibroids	☐Endometriosis	☐Warts/Herpes
☐Ovarian cysts or tumors	☐Premenstrual syndrome	☐Pelvic Infection
☐Loss of urine or feces	☐ Vaginitis (yeast, BV, trich)	☐Chlamydia/Gonorrhea
☐Infertility issues	☐Herpes	☐Breast/Chest Pain/Discharge

Health & Nutrition

I exercise _______ times a week. What type of exercise do you do?______________________________
I take calcium. Yes No How much? _________ I take vitamin D. Yes No How much? _______
Amount of drink in a week: alcohol ______ tea ______ coffee ______
Do you smoke? Yes No If yes, how much? _______________
Do you use street drugs? Yes No If yes, what kind and how often?

Describe your diet.

Medical and Family History ☐**I have no knowledge of my family history.**

Check if YES:	Self (S)	Family (F)	Check if YES:	S	F	Check if YES:	S	F
Breast cancer			High cholesterol			Skin problems		
Insomnia			Muscle/joint pain			Vision problems		
Ovarian cancer			High blood pressure			Jaundice/hepatitis		
Colon cancer			Blood clots lungs/legs			Asthma		
Uterine cancer			Thyroid problems			HIV/AIDS		
Other cancer			Lung problems			Anemia		
Diabetes			Breast problems			Birth defects		
Heart disease			Colon/Stool problems			Varicose Veins		
Rheumatic fever			Reflux/ulcer			Migraines		
Stroke			Stomach problem			Headaches not migraines		
Osteoporosis/Fracture			Gall bladder problem			Seizure/epilepsy		
Shortness of Breath/Chest Pain			Kidney/bladder problem			Depression		
Arthritis/joint pain			Urine infections			Anxiety		

List any hospitalizations, surgeries, accidents or serious illness and their year.

Please list any medications, herbs, vitamins, and supplements you are taking:

Prevention

Because it is so common and we are concerned about your safety, we ask all patients about the presence of violence in their home and relationships. We want you to be safe, and we can help. Are you being:

☐Hurt ☐Threatened with physical harm
☐Insulted or talked down to ☐I have a history of sexual/physical abuse.
☐Screamed at or cursed

To the best of my knowledge, the questions on this form have been answered correctly.

____
Patient Signature Date

I have read and reviewed the information provided by the patient/guardian above.

____
Provider Name and Signature Date

Credit Card Payment Authorization Form

Sign and complete this form to authorize Eastside Total Health & Lactation to debit your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission is for today AND future payments applied to my account after services have been rendered.

Please complete the information below:

I ______________________________ authorize Eastside Total Health & Lactation to charge my credit card
(full name)

account as needed on or after ____________________. This payment is for services rendered and after

my insurance has been billed (if applicable).

*Eastside Total Health will contact me for a verbal authorization to run this card on file for debits greater than $500.00. Payments will be applied to outstanding balances between the 25th-30th day of the month.

Billing Address ______________________________ Phone# __________________________

City, State, Zip ______________________________ Email __________________________

Account Type: ☐ Visa ☐ MasterCard ☐ Flex or Benefit Card?

Cardholder Name ____

Account Number ____

Expiration Date _____________

CVV _____________

SIGNATURE ____ DATE _____________________

I authorize Eastside Total Health & Lactation to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amount indicated above only, and is valid on file until I discontinue this authorization in writing. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

EASTSIDE TOTAL HEALTH & LACTATION

Family Building Fee Schedule

Initial Consultation	$250.00
Management of care- Return visit	$160.00
Sperm Isolation	$200.00
Microscope	$225.00
Insemination	$260.00
Missed Appointment or same day cancelation	$ 50.00
Non-Sufficient Funds	$ 25.00
Routine Annual Pap	$165.00-$240.00 (depending on age)
Telemed Visit	$ 85.00-$160.00 (depending on length)
Sonogram Limited	$175.00

Prices listed above does not include the following:

- Lab work
- Medications
- Sperm storage and/or transport

Please contact our Business Manager if you have questions regarding insurance processing or the above references Fee Schedule. This Fee Schedule is applicable to those patients who are underinsured or have an active insurance policy with which Eastside Total Health & Lactation does not contract with. Military discounts apply, please ask!

December 2016