REGISTRATION FORMS

Name:	Today's Date:	
Birth Date & SSN:	Baby's Full Name, Gender & Birth Date:	
Street Address:	City, State, Zip:	
Cell Phone:	Home:	Work:
Occupation:	Employer:	
Email:	Pediatrician 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 #:	
Baby's Insurance (if different from Mom):	Subscriber Name & SSN:	
Group #:	Policy #:	
IN CASE OF EMERGENCY		
Name: Relationship: Cell Phone: 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 Women's Health Center (EWHC) to provide medical care and treatment for me. I authorize payments of benefits to be made directly to EWHC. 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:	

ETH&L 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 Women's Health Center and by signing below:

I hereby authorize Eastside Women's Health Center 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 Women's Health Center.

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 Eastside Women's Health Center 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 Women's Health Center that is available on the website**.** I understand that if I have objections or concerns with this policy, I must notify Eastside Women's Health Center.

_____ _____

Name of Patient (Print) *Signature of Patient*

Today's 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.

Lactation Visits: Often times mom and babe are seen as a separate patient and billed individually. There are many reasons why mom and babe would be considered as separate entities. This assessment, management and plan for each are not always the same. A copay may be collected and insurance may be billed for each patient on the same day based on the evaluation in the visit. **Patient Initials: _____**

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 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*

Today's 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 and insurance has determined that I owe a portion subject to patient responsibility.

Please complete the information below:

I _____ authorize Eastside Total Health & Lactation to charge my credit card (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 $200.00. 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 (HSA or FSA)

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV _____

☐ My insurance is through DSHS and I do not have any patient responsibility after my insurance policy has processed my claim for services.

PRINT NAME _____ 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.