Coho Medical Group

Patient Information:

Appointment Date: _____/_____/_____

Patient Name: _____

Date of Birth: _____/_____/_____

Email Address: _____

Gender: _____

Marital Status: Single/ Married/ Divorced/ Widowed

Address: _____

_____

City :_____ State:_____ Zipcode:_____

Phone: Mobile:_____

Home:_____

Work: _____

Emergency Contact: Name_____ Phone#:_____

No-Show/Cancellation Policy

I,_____ Consent to and understand the following policy:

It is understood and agreed that the office requires that all patients provide a 24-hour cancellation notice. Failure to cancel or show for a scheduled appointment will result in a **$50.00** charge for each occurrence.

I am aware that this charge cannot be billed to my insurance and that I will be responsible for this fee.

I CERTIFY THAT I HAVE READ THIS FORM AND THAT I UNDERSTAND IT'S CONTENTS. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION AND I ACKNOWLEDGE RECEIPT OF A COPY OF THIS FORM.

Signature of patient:_____

Date:_____ Time:_____

The patient is unable to consent because:

_____

_____

_____

_____

Signature:_____ Relationship:_____

Date:_____ Time:_____ Witness:_____

OPT-IN Consent
For Calls and Messages

By signing this agreement, you specifically request, expressly consent to receive, and authorize Coho Medical Group, its affiliates, business associates, and service providers to deliver, or cause to be delivered, calls and SMS/text and voice messages to your cell phone, and residential line as applicable, **using an automatic telephone dialing system and/or using an artificial or pre-recorded voice.** This could result in charges to you according to your data plan. These calls and messages will be for health care and other purposes including but not limited to, for the purpose of treatment, appointment reminders and office closure announcements, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for the purpose of servicing your account, payment and billing, and collecting any amounts you may owe.

If at any point you change or obtain a new phone number, or if you no longer maintain the phone number you originally provided to us, you agree to notify Coho Medical Group immediately of such change by calling the office or emailing help@cohomedical.com. You agree to provide your full name, address, and date of birth in your notification.

You may be held liable for failure to do so, as outlined in the following provision:
Indemnity Provision - READ CAREFULLY:
You agree to indemnify and hold Coho Medical Group, its officers, agents and employees harmless from any liability, loss or damage, including but not limited to, attorney's fees, they may suffer as a result of claims, demands, costs or judgments against them arising out of alleged violations of the Telephone Consumer Protection Act or similar laws, resulting from autodialed or artificial or pre-recorded voice calls placed to an incorrect or reassigned phone number(s), originally belonging to you or which you provided to Coho Medical Group, but of which you failed to timely notify Coho Medical Group that such number(s) was incorrect or no longer assigned to you.

Opt-In
I,_____ authorize and expressly consent to receiving calls and SMS/text and voice messages delivered to my phone number:_____ placed by Coho Medical Group, its affiliates, associates, and service providers, from an automatic telephone dialing system and/or using an artificial or pre-recorded voice, for health care and other purposes, including treatment, appointment reminders and office closure announcements, clinic operations, telemarketing and advertising possible treatment alternatives and other health-related benefits and services that may be of interest, and for servicing my account, payment and billing, or collecting amounts I may owe. I agree to notify Coho Medical Group immediately if I change or obtain a new phone number, or no longer maintain the phone number provided herein, and expressly acknowledge that I may be held liable for failure to do so, as outlined above.

I understand that I need not sign this form as a condition to purchase goods or services and that SMS/text messages and voice messages carry certain risks. For example, messages may be sent in unencrypted form. They could be received by others if others have access to my device or if my messages are sent to another device. I understand the risks, and I expressly consent to receiving these messages and ask Coho Medical Group to communicate with me in this form.
I have read this disclosure in its entirety and agree that Coho Medical Group, its affiliates, business associates and its service providers may contact me as described above.

Signature of patient:_____ Date:_____ Time:_____

The patient is unable to consent because:

_____

Signature:_____ Relationship:_____ Date:_____ Time:_____

Witness:_____

FINANCIAL POLICY

As a courtesy to our patients, our facility will provide the service of billing your insurance carrier. However, practical benefits are not determined until a claim is received by your insurance company. When requested, our group can provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party. For patients without coverage by an insurance carrier, an initial payment equal to no less than one half (1/2) of the total cost for the ordered test(s) is due at the time service is rendered. Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance. A Non-sufficient Funds (NSF) Fee of $25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to Coho Medical Group/ Bellevue Suboxone Clinic and/or the affiliated entities or otherwise at its direction. I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment(s) and coverage for services and/or supplies provided to me by Coho Medical Group/ Bellevue Suboxone Clinic. AUTHORIZATION TO

APPEAL ON PATIENT'S BEHALF

I further authorize Coho Medical Group/ Bellevue Suboxone Clinic and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare if I am a Medicare beneficiary. I understand that in the event of an adverse decision made by my insurance carrier(s) as it relates to coverage, authorization or payment(s), Coho Medical Group/ Bellevue Suboxone Clinic is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier. I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUB-SECTIONS WITHIN.

Patient Signature: _____ Date: _____

Patient Name (printed): _____

If applicable, please print the name of the Patient's Representative: _____

Relationship to the patient: _____

Acknowledgement of Receipt of Notice of Privacy Practice And Patient Rights Form

This document provides acknowledgement of receipt of Coho Medical Group's Notice of Privacy Practices and Patient Rights Form. Coho Medical Group/ Bellevue Suboxone Clinic maintains strict compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the guidelines set therein. Any questions you have regarding the information provided in the Coho medical Group/ Bellevue Suboxone Clinic Notice of Privacy Practices or Patient Rights Forms should be directed to Coho Medical Group Bellevue Suboxone Clinic Administrative staff or the Privacy Officer indicated on the Privacy Practice. I understand that certain disclosures are required under federal law and may be released by Coho Medical Group/ Bellevue Suboxone Clinic, upon request from an authorized entity, as outlined below:

Public Health Activities
Health Oversight Activities
Law Enforcement
Coroners, Medical Examiners and Funeral Directors
Organ and Tissue Donation
Certain research projects
Disclosures necessary to prevent serious threats to health or safety
Military Command Authorities; if you are a member of the armed forces or foreign military authority National Security and Intelligence
Worker's Compensation Payers; and
Disclosures necessary to initiate and complete health care treatment
Payment and operations or functions by business associates I further understand that the disclosures outlined below may be considered optional and that I may choose to 'opt out' of these types of disclosures by selecting 'decline' for any or all circumstances below.
Family members or close friends who are involved in your care or payment for treatment
□ DECLINE
Disaster Relief Agencies; if you are involved in a disaster relief effort; and DECLINE
Information provided to you regarding alternative treatments for your health care DECLINE

I have been given, and have read and understand my rights under the Notice of Privacy Practices. I have been given, and have read and understand my rights under the Patient Rights Form.

Patient Signature: _____ Date: _____

Patient Name (printed): _____

If applicable, Patient's Representative: _____

Relationship to the patient: _____

Representative Signature: _____ Date:_____

Review Of Systems

Name:_____D.O.B._____ □Male □Female

Please Check the box if you have experienced any of the following symptoms or conditions. If none check the negative box.

General: □ negative

□ Recent Weight Loss □ Recent weight gain □ Fatigue □ Rheumatic fever
□ Loss of sleep □ Loss of appetite □ Night Sweats □ Cancer of any kind

Integumentary (skin): □ negative

□ Skin problems □ Skin rashes □ Psoriasis □ Skin cancer
□ Slow healing □ Discolorations □ Change in moles □ Scars
□ Bruise easily □ Itching □ Sores □ eczema

Neurological: □ negative

□ dizzy □ Fainting □ disorientation □ weakness
□ memory loss □ concussion □ loss of coordination □ numbness
□ difficulty speaking □ headaches □ difficulty walking □ tingling
□ multiple sclerosis □ migraines □ stroke □ tremors
□ Parkinson's Disease □ Epilepsy/seizures □ Alzheimer's Disease □ Disk problems

Eyes, Ears, Nose and Throat: □ negative

□ Vision Problems □ Glaucoma □ Ear pain □ Sore throat
□ Blurred vision □ Hearing loss □ Mouth sores □ Nose bleeds
□ Double vision □ ringing in ears □ Hoarseness □ Dental problems
□ Ear Congestion □ Nasal Congestion □ Eye Pain □ Runny Nose

Endocrine: □ negative

□ Hypothyroidism □ Hyperthyroidism □ Diabetes □ Goiter

Respiratory: □ negative

□ Coughing □ Pneumonia □ Sleep apnea □ Bronchitis
□ Coughing up blood □ Difficulty breathing □ Chest Pain □ Emphysema
□ Chronic cough □ Asthma □ Tuberculosis □ Lung cancer

Cardiovascular: □ negative

□ Pain over the heart □ Pressure over chest □ High blood pressure □ Shortness of breath
□ Heart attack □ Pain down left arm □ Low blood pressure □ Profuse sweating
□ Irregular heartbeat □ Calf Pain with walking □ High triglycerides
□ Murmurs □ Swelling of ankles □ High cholesterol

Gastrointestinal: □ negative

□ Gallbladder problems	□ Pain over stomach	□ Constipation	□ Blood in the stool
□ Liver trouble	□ Burning in stomach	□ Diarrhea	□ Mucus in stool
□ Hepatitis	□ Ulcers	□ Hiatal hernia	□ Pancreatitis
□ Heartburn	□ Colitis	□ Colon cancer	□ Crohn's disease
□ Nausea	□ Vomiting	□ Rectal Bleeding	□ Rectal itching/pain

Genitourinary: □ negative

□ Painful Urination	□ Frequent urination	□ Kidney infection	□ Kidney stones
□ Blood in urine	□ Incontinence	□ sexual difficulty	□ Loss of libido

Hematologic: □ negative

□ Anemia	□ Bleeding disorder	□ Sickle cell anemia	□ Lymphoma

Musculoskeletal: □ negative

□ Arthritis	□ Head injury	□ Cancer	□ Muscle pain
□ Osteoarthritis	□ Neck injury	□ Muscle weakness	□ Gout
□ Rheumatoid arthritis	□ Back injury	□ Osteoporosis	□ Scoliosis
□ Bone spurs	□ Spinal trauma	□ Muscular Dystrophy	□ Lupus
□ Broken bones	□ Birth Trauma	□ Scheueman's Disease	□ Spina Bifida
□ Compression fracture	□ Birth defects	□ Joint pain	□ Spondylolisthesis

Allergic/ Immunologic: □ negative

□ Catch colds easily	□ Frequent Sinusitis	□ Frequent influenza	□ Fever
□ HIV	□ AIDS	□ Allergies	□ Hay fever

Psychiatric: □ negative

□ depression	□ anxiety	□ difficulty concentrating	□ paranoia
□ feelings of guilt	□ under or overeating	□ trouble with sleep	□ lack of energy

Women Only: □ negative

□ Irregular periods	□ Nipple discharge	□ Premenstrual depression
□ Hot flashes	□ Ovarian cancer	□ Lumps in breasts
□ Vaginal discharge	□ Abnormal Pap smear	□ Hysterectomy

Men Only: □ negative

□ Burning with urination	□ Nightly urination	□ Prostate trouble	□ Testicular Pain
□ Difficulty urinating	□ Dripping after urination	□ Prostate cancer	

Reviewed by Doctor:_____**Date**:_____

Short Patient Health Questionnaire (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things?	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
Feeling down, depressed, or hopeless	0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day
Total point score:	

Patient Rights

As an individual receiving services through Coho Medical Group/ Bellevue Suboxone Clinic, you have the right:

To receive services regardless of your race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
To receive services that support and respect the patient's individuality, choices, strengths, and abilities.
To receive privacy in care for personal needs.
To receive a referral to another health care institution if the provider is unable to provide physical health services or behavioral health services for the patient.
To receive assistance from a family member, representative, or other individual in understanding, protecting, or exercising the patient's rights.
To be treated with consideration, respect and dignity, including privacy in treatment.
To not subjected to: Abuse; Neglect; Exploitation; Coercion; Manipulation; Sexual abuse; Sexual assault; Seclusion; Restraint, if not necessary to prevent imminent harm to self or others; Retaliation for submitting a complaint to the Department or another entity; or Misappropriation of personal and private property by a unclassified health care institution's personnel members, employees, volunteers, or students; and A patient or the patient's representative
To be information of the patient compliance process.
To be given the opportunity to give consent to photographs of the patient before a patient is photographed except that a patient may be photographed when admitted to a healthcare institution for identification and administrative purposes.
To provide written consent to the release of patient's medical records and financial records.
To express complaints about the care and services provided and to have the health center investigate such complaints. Coho Medical Group / Bellevue Suboxone Clinic is responsible for providing you or your designee with a written response within 30 days, if requested, indicating the findings of the investigation.

Coho Medical Group / Bellevue Suboxone Clinic is also responsible for notifying you or your designee that if you are not satisfied by our response, you may complain to the Washington State Department of Health Office.

Submit complaints in writing to: Coho Medical Group/ Bellevue Suboxone Clinic
1515 116th Ave Ne
Bellevue, WA 98004

HIPAA COMPLIANCE NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include the Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, as applicable, RCW Chapter 70.02 entitled "Medical records-- Healthcare Access and Disclosure." Please review it carefully.

We, at Coho Medical Group/ Bellevue Suboxone Clinic, understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires me to do so.

The law protects the privacy of the health information We create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Protected Health Information (PHI): Protected health information means individually identifiable health information, which is : transmitted by electronic means, maintained in any means described in the definition of electronic media; or transmitted or maintained in any other form or medium.

Examples of use and disclosures of Protected Health Information for *Treatment, Payment, and Health Operations are:*

Treatment:

• information obtained by a nurse, physician, clinical psychologist, MSW, therapist, or other member of the treatment team will be recorded in your medical record and used to help decide what care may be right for you.

• We may also provide information to others providing you care. This will help them stay informed about your care.

Payment:

• In Washington State, written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form "Assignment of Benefits" or a similar form for this purpose (RCW 70.02.030(b). Health plans need information from me for your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

Health care operations:

• We may use your medical records to assess quality and improve services.

• We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefits and services.

• We may use and disclose your information to conduct and arrange for services, including: - medical review by your health plan; - accounting, legal, risk management, and insurance services; - audit functions, including fraud and abuse detection and compliance programs.

Your health information rights.

The health and billing records we create and store are the property of Coho Medical Group. The protected health information in it, however, generally belongs to you.

You have a right to:
• Receive, read, and ask questions about this notice;
• Ask us to restrict certain uses and disclosures. You must deliver this request in writing to me. We are not required to grant that request. But we will comply with any request granted;
• Request and receive from me a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
• Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
• Have us review a denial of access to your health information—except in certain circumstances.
• Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
• When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to 3rd party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once every twelve months.
• As that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
• Cancel prior authorizations to sue or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Psychotherapy notes:

These are notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record. Psychotherapy notes excludes medication prescriptions and monitoring, counseling session start and stop times, the modalities or frequencies of treatment provided, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. An authorization to use or disclose psychotherapy notes is required except if used by the originator of the notes for treatment, to a person or persons reasonably able to prevent or lessen the threat (including the target of the threat), if the originator believes in good faith that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, if the notes are to be used in the course of training students, trainees or practitioners in mental health; to defend a legal action or any other legal proceeding brought forth by the patient; when used by a medical examiner or coroner; for health oversight activities of the originator; or when required by the law.

Our responsibilities.

We are required to:

-Keep your protected health information private.
-Give you this notice.
-Follow the terms of this Notice.

We have the right to change my practices regarding the protected health information We maintain. If We make changes, We will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it.

To ask for help or to make a complaint.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, contact Coho Medical Group/ Bellevue Suboxone Clinic, 1515 116th Ave NE, Bellevue, WA 98004.

If you believe your privacy rights have been violated, you may discuss your concerns with the Privacy Officer. You may send a written complaint to the Washington State Department of Health at: 510 4th Ave. W., Suite 404, Seattle, WA 98119.

You may also file a complaint with the U.S. Secretary of Health and Human Services. We respect your right to file a complaint with me or to the Secretary of HHS, and We will not retaliate against you.

Other disclosures and uses of Protected Health Information.

Notification of family and others.

Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

Other use or disclosure of your Protected Health Information without your authorization is:

• With medical researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
• To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products.
• To comply with Workers' Compensations Laws if you have made workers' compensation claims.
• For Public Health and Safety Purposes as allowed or required by law: -to prevent or reduce a serious, immediate threat to the health or safety of a person or the public. -to public health or

legal authorities. -to protect public health and safety -to prevent or control disease, injury, or disability -to report vital statistics such births or deaths.
• To report suspected abuse or neglect to public authorities.
• To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
• For law enforcement purposes such as when we receive a subpoena, court order, or other legal process, or you are a victim of a crime.
• For health and safety oversight activities. For example we may share health information with the Department of Health.
• For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies t assist in notification of your condition to family or others.
• For work related conditions that could affect employee health. For example, an employer may ask me to assess health risk on a job site.
• To the military authorities of U.S. and foreign military personal. For example, the law may require me to provide information necessary to a military mission.
• In the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
• For specialized government function. For example, we may share information for national security purposes.

Specialized Authorizations

Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information.
When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state laws such as:

• Uniform Health Care Information Act (RCW 70.02)
• Sexually Transmitted Diseases (RCW 70.24.105)
• Drug and Alcohol Abuse treatment Records (RCW 70.96S.150)
• Mental Health Services for Minors (RCS 71.05.390-690)
• Communicable and Certain other Diseases Confidentiality (WAC 246-100-016)
• Confidentiality of Alcohol and Drug Abuse Patients (42 CFR Part 2)

If we need your health information for any reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. More important, if you choose to sign an authorization to disclose information, you may revoke that authorization at a later time to stop any future use and disclosure.

Other uses and Disclosures of Protected Health Information

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Effective date: January 1, 2016