Morgan Family Medicine

Authorization to Release Healthcare Information

Patient's Name: ___________________________________Date of Birth: _________________

Previous Name: ___________________________________ SS#: _________________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ____________________ State: __________ Zip Code: __________

This request and authorization applies to:

□ Healthcare information relating to the following treatment, condition, or dates:

____

____

□ All healthcare information

□ Other: ____

Definition: Sexually transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□ Yes □ No I authorize the release of my STD results, HIV/Aids testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____________________________________ Date Signed:_____________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Morgan Family Medicine

Financial Policy/Payment of Services

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash or credit cards (i.e.; VISA, Mastercard, Discover and American Express)

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment. If your insurance requires a referral it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.
- If you have Medicare, PART B only you are responsible for your Medicare deductible and your 20% of the charges at the time of service.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- If you have an x-ray performed, you will receive a separate bill from SINGLETON and ASSOCIATES. These are the radiologists who read your x-rays and send a report to PCCS.
- PCCS charges a $30.00 fee for failure to cancel your appointment within 48 hours of your scheduled appointment time.

Signature of Responsible Party: ______________________________________ Date: ____________

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New Patient Medical History and Physical Form

Today's Date:____________

Name: ________________________________ Date of Birth: ______________

Reason for your visit: ____

Personal Medical History: Have you ever had any of the following conditions? (Check all that apply)

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Cancer ☐ Chronic Obstructive Pulmonary ☐ Disease ☐ Clotting Disorder ☐ Congestive Heart Failure	☐ Crohn's Disease ☐ Depression ☐ Diabetes ☐ Emphysema ☐ Endocrine Problems ☐ GERD ☐ Glaucoma ☐ Hepatitis ☐ HIV/AIDS	☐ Hypertension ☐ Kidney Disease ☐ Myocardial Infarction ☐ Peptic Ulcer Disease ☐ Seizures ☐ Stroke ☐ Ulcerative Colitis

Personal Surgical History: Have you ever had any of the following surgeries? (Check all that apply)

☐ Adrenal Gland Surgery ☐ Appendectomy ☐ Bariatric Surgery ☐ Bladder Surgery ☐ Breast Surgery ☐ Cesarean Section ☐ Cholecystectomy	☐ Solon Surgery ☐ Coronary Artery Bypass Graft ☐ Esophagus Surgery ☐ Gastric Bypass Surgery ☐ Hemorrhoid Surgery ☐ Hernia Repair ☐ Hysterectomy	☐ Kidney Surgery ☐ Neck Surgery ☐ Prostate Surgery ☐ Small Intestine Surgery ☐ Spine Surgery ☐ Stomach Surgery ☐ Thyroid Surgery

Medications (current):

____

____

____

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Allergies:

____
____
____

Family History: Has anyone in your family had any of the following conditions?

(Check all that apply. If applies, indicate the relationship to you.)

☐ Cancer/Polyps: ________________________ Colon, Rectum, Anal, Stomach, Breast, Prostate, Uterus, Ovarian, Thyroid, Lung, Blood, Lymphoma Other ____________________ ☐ Hepatitis _________________	☐ Anemia ________________ ☐ Diabetes ________________ ☐ Blood Clots ________________ ☐ Heart Disease ________________	☐ High Blood Pressure _______________ ☐ Anesthesia Reaction _______________ ☐ Bleeding Problems _______________

Social History:

Alcohol Use: ☐ Never ☐ Occasionally ☐ Daily Type _____________________

Tobacco Use: ☐ Never ☐ Previously, but quit ☐ Packs Per Day _____for ______years

Drug(s) Use: ☐ Never ☐Occasionally ☐ Daily Type _____________________

What is your occupation? ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Name of spouse or significant other: ____

Children: Number of Children ___________ Number of Grandchildren _______________

Women: Number of Pregnancies ________ Number of Deliveries _________

Vaginal ________ C-sections ________ Miscarriages ________

VIP's (abortions) _________

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Cancer health habits: (Circle response)

Women:		**Men:**	
Breast: Monthly self-exam	Y N	Prostate: Yearly rectal exam	Y N
Yearly physician exam	Y N	Yearly PSA blood test	Y N
Last mammogram	Y N	**All:**	
GYN: Yearly GYN exam	Y N	Skin: High sun exposure	Y N
Yearly PAP exam	Y N	Yearly skin exam	Y N

Colon:

Yearly rectal exam Y N

Yearly stool test for blood Y N

Date of last colonoscopy _______________

For Office Use Only

BP: ____/_____ Pulse: ____________ Temp: ___________

Weight: ______________ Glucose: ___________

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Medical Consent and Authorization for Treatment

Patient Name:_______________________________ Phone#: _______________________

DOB: ____________________

Consent for Services:

I _______________________________ consent to medical treatment from Morgan and Davis Family Medicine for _____________________________________.
(Name of Patient)

I consent to allow release of medical information when needed for treatment, payment and for state agencies.

I allow Morgan and Davis Family Medicine to speak for me when working with insurance companies on my eligibility.

I allow Morgan and Davis Family Medicine to do procedures and treatments per orders of Nurse Practitioners.

I have received a copy of Privacy Practice from Morgan and Davis Family Medicine.

My signature below shows that I understand and agree with the above information and age consent for all healthcare services by Morgan and Davis Family Medicine.

____ _________________________
Patient or Representative Date

____ _________________________
Relationship to Patient Reason patient can't sign

____ _________________________
Witness Date