TUMWATER *family practice* CLINIC

▪ 150 Dennis St SW ▪ Tumwater, WA 98501 ▪ Phone: 360-754-6367 ▪
▪ www.tfpclinic.com ▪

Welcome to Tumwater Family Practice Clinic! We are honored that you have chosen us as your health care provider. Our goal is to provide the highest quality care for all of our patients in a timely and respectful manner.

Your new patient appointment:

DATE: _____TIME: _____ CHECK IN TIME: _____

We are open 7 days a week! Our office hours are Monday-Thursday 8:30am-6:00pm, Friday 8:30am-5:30pm. Saturday and Sunday 9:00am-5:00pm are for acute care.

Please bring your insurance card and photo ID with you to each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment may need to be rescheduled. You will be asked to fill out new registration forms annually.

All co-pays, deductibles and past due balances are expected at time of service, unless an agreement has been made with our billing department. Our billing department is available Monday-Friday from 8:30am-5:00pm.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay to be seen and we will keep you informed of how long of a delay you may experience.

Our office policy for a missed appointment is:

- If it is an appointment for a new patient, the appointment will not be rescheduled.
- Three (3) no-show appointments will result in dismissal from the practice.

We understand that appointments sometimes need to be changed, so we ask that you call in advance if you cannot keep your scheduled appointment. Our policy is to charge a $40.00-$50.00 fee for missed appointments not cancelled within 24 hours.

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the Patient Portal. The Portal is completely secure and HIPAA compliant to ensure the safety of your Personal Health Information. To become web-enabled, simply speak with someone at our front desk. Once you give us your email address, we can set up your web ID and password. Then you can start using this great new method of communication!

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. **Tumwater Family Practice Clinic does not offer chronic pain management and will not dispense chronic pain medication**. Our clinic is unable to conduct care for new or established patients with ongoing chronic pain and/or narcotic prescriptions.
2. If you are on a medication that requires refills for a chronic disease (for example, high blood pressure or diabetes), you will typically be given ample refills for 30 or 90 days at a time during your office visit.

    a. When you are down to a 30 day supply of medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.
3. For the safety and well-being of our patients,
    a. Requests for new medications (including antibiotics) will not be taken over the phone or over the Internet during office hours without an appointment and evaluation by the physician.
    b. No new medications (including antibiotics) will be called in over the phone after office hours by the on-call physician.
4. Please contact your pharmacy for prescription refills and they will send the request to us. Prescription refills will only be addressed during weekday hours, please expect 48-72 hours for processing.

If the patient is a minor child we require a legal parent or guardian present for the appointment. Step parents or any other family member/friend does not constitute legal parent/guardian unless there is adoption paperwork or legal paperwork constituting this person as "Guardian". Please, bring this paperwork if this is the case. We also request that if the New Patient is a minor child that an immunization record be either faxed to our clinic or brought into appointment regardless of the reason for appointment. Be aware that if your child is in need of immunizations and there is not an immunization record present, we will not be able to provide vaccinations at that visit.

Our clinic standing with regard to vaccinations is that all patients under our care receive all childhood vaccinations as recommended by the CDC. Please, understand we don't wish to interfere with your personal choice as a parent/guardian, however we have to do what is best for all of our patients and this community. If you choose not to have your child vaccinated appropriately, you will need to seek healthcare from another practice.

Tell us how we are doing! We encourage our patients to provide feedback about the care and service they receive. If you have any questions, concerns or comments, please let us know during your visit, give us a call at 360-754-6367 ext. 116 or send an email to alisons@tfpclinic.com.

Once again, we would like to thank you for choosing us as your primary care provider. We look forward to working with you!

Sincerely,
The Providers and Staff of Tumwater Family Practice Clinic

TFPC Medication and Allergy Update Form **Name: _____**

Current Medications: Use reverse side of the form if needed

Name of Medications	Dose	How often you take it	What you take it for

Allergies:

_____

_____

_____

Tumwater Family Practice Clinic – Pediatric Medical History Form

Parents – please help us by answering the following questions about your child's history.

Patient Name: _____ Date of Birth: _____ PCP Provider: _____

Please complete this sheet by filling in the bubbles completely.

Birth History:

Adopted	O Yes	Birth by C-Section	O Yes
Problems during Pregnancy	O Yes	Problems after Delivery	O Yes
Premature	O Yes	Low birth weight	O Yes

General History: Have the following occurred to your child:

Hospitalization(s)?	O Yes	Describe: _____
Allergic Reaction(s)?	O Yes	To What: _____
Are there developmental concerns?	O Yes	Describe: _____
Are Immunizations Current?	O Yes	O No

Medical History: In the past has your child been diagnosed with any of the following:

ADD	O Yes	Learning difficulty	O Yes	Esophageal reflux	O Yes
Allergies	O Yes	Poor weight gain	O Yes	Failure to thrive	O Yes
Autism	O Yes	Stuttering	O Yes	Heart Murmur	O Yes
Depression	O Yes	Undescended testis	O Yes	Hernia	O Yes
Ear Infections – Chronic	O Yes	Birth Defect(s)	O Yes	Lactose Intolerance	O Yes
Exposure to cigarette smoke	O Yes	ADHD-hyperactive/impulsive	O Yes	Milk protein allergy	O Yes
Seizures	O Yes	Asthma	O Yes	Speech/language delay	O Yes
Heart Problems	O Yes	Constipation	O Yes	Umbilical hernia	O Yes
Insomnia	O Yes	Developmental delay	O Yes	UTI	O Yes

Family History: Have any of the family members listed been diagnosed with the following:

Mother:

O Allergies O Asthma O Cancer O Diabetes O Arthritis O Seizures O Stroke
O Mental Illness O Alcoholism O Heart Disease O Hypertension O Heart Attack O Kidney Problems
O Thyroid Problems O Bleeding Disorder

Father:

O Allergies O Asthma O Cancer O Diabetes O Arthritis O Seizures O Stroke
O Mental Illness O Alcoholism O Heart Disease O Hypertension O Heart Attack O Kidney Problems
O Thyroid Problems O Bleeding Disorder

Siblings

O Allergies O Asthma O Cancer O Diabetes O Arthritis O Seizures O Stroke
O Mental Illness O Alcoholism O Heart Disease O Hypertension O Heart Attack O Kidney Problems
O Thyroid Problems O Bleeding Disorder

**** See reverse side to list any other medical issues as well as any surgeries they have had****

Tumwater Family Practice Clinic – Pediatric Medical History Form

Please list any past or ongoing medical issues not specified on the front:

_____

_____

_____

_____

Please list types and dates of any surgeries they have had:

_____

_____

_____

_____

Tumwater Family Practice Clinic
Pediatric Patient Information Form

It's very important we have your Patient/Family information correct- PLEASE PRINT CLEARLY

Patient Name: _____ Date of Birth: _____

Mailing Address: _____
(Street or PO box) (APT #) (City) (State) (Zip)

*We will send Billing Statements, Lab Results and all other correspondence to this address.

Primary Phone #: _____ ☐Cell ☐Home ☐Other: _____
(Appointment reminder calls will be sent to this number)

Secondary Phone #: _____ ☐Cell ☐Home ☐Other: _____

Patient's Direct Phone #: _____ (Patients over 12 years of age)

Birth Gender: ☐Male ☐ Female Other Gender Identity (If applicable):_____
Race: ☐White ☐ Asian ☐Black or African American ☐American Indian ☐Other Race: _____
Ethnicity: ☐Non-Hispanic ☐ Hispanic Origin ☐Unknown

Preferred Pharmacy: Name: _____ Location: _____

Primary Contact Adult: (Same contact information as above)
Check one: ☐ Biological Parent ☐Step-Parent ☐ Adoptive-Parent ☐ Foster-Parent ☐Legal Guardian

Name: _____ Date of Birth: _____

SSN # (or) Drivers License #: _____

Secondary Contact Adult:
Check one: ☐ Biological Parent ☐Step-Parent ☐ Adoptive-Parent ☐ Foster-Parent ☐Legal Guardian
Name: _____ Date of Birth: _____

SSN # (or) Drivers License #: _____ Phone #: _____

Address: _____
(If different from patient's address)

Emergency Contact: (Other than either parent listed above or outside of household)

Name: _____ Phone: _____ Relation: _____

Who has primary physical custody?: _____

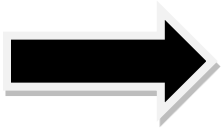
In order to obtain more accurate Family Medical History requirements, if contacts listed above are NOT the BIOLOGIAL PARENTS, we now necessitate BOTH BIOLOGICAL PARENTS (if known) to be listed.

Biological Mother: _____ Date of Birth: _____
Biological Father: _____ Date of Birth: _____
*If either biological parent listed above has **NO** parental rights per a **SIGNED COURT ORDER**, a copy of that COURT ORDER is required to be on file.

Please list any other persons, if any, who may accompany your child to appointments and consent for treatment.
Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

PLEASE COMPLETE AND SIGN BACK SIDE



Please list any persons who are specifically NOT allowed to consent for treatment. If a child's parent is listed, please provide us with a copy of legal documents regarding custody or specific restrictions.

Name: _____ Relation: _____

Insurance Information:

If insurance cards are not presented at each visit, you may be considered self-pay.

Is patient covered by Medicaid or Healthy Options? ☐YES ☐NO

If patient is a newborn, have they been added to your insurance? ☐YES ☐NO

If required by your insurance, have you selected our office as your PCP? ☐YES ☐NO

Primary Insurance: _____

Insurance Name Subscriber's Name and DOB ID # Group #

Secondary Insurance: _____

Insurance Name Subscriber's Name and DOB ID # Group #

Who may we discuss account/billing information with?

☐Mother(s) ☐ Father(s) ☐Grandparents ☐Any member of my immediate family ☐Other: _____

I understand both biological parents, unless their parental right have been terminated either through a court order or through the adoption process have access to full disclosure of their child's medical information and can authorize someone to bring their child to their appointments in the absence. Access to medical information is not limited to the main custodial parent for access.

I understand, in the interest of building a trusting relationship with our adolescents and teenagers, the providers may not be able to discuss all teenage issues discussed at appointments with the parents, unless the physician feels that the patient is a danger to themselves or has been abused.

I authorize Tumwater Family Practice Clinic to fax any forms or immunization records to my child's school.

I understand that Tumwater Family Practice Clinic provides immunization information to the Washington State Immunization Information System.

Financial Policy and Agreement

I hereby authorize release of information necessary to file a claim with my insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and any changes to your insurance or demographics. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does and does not cover and the provider and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by your insurance company. A copy of this signature is just as valid as the original.

Authorization for Treatment of a Minor

I hereby authorize the providers of Tumwater Family Practice Clinic to provide medical care to the above named minor child.

Signature_____ Relation to patient: _____

Printed Name: _____ Date: _____

Patient Name: _____ Date of Birth: _____

TUMWATER FAMILY PRACTICE
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. This is your Protected Health Information or PHI. You may ask to see and have that record copied. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information by contacting our HIPAA Officer.
Our Notice of Privacy Practice describes in detail how your health information may be used and disclosed, and how you can access your information. If you wish to have a copy, please inform the receptionist.
I acknowledge that I was offered a copy of Tumwater Family Practice Clinic's Notice of Privacy Practices.

In addition to the allowable disclosures in the NPP, I hereby specifically authorize disclosure of my (or my child's) PHI to the persons indicated below.

Name	Relationship	Phone #

Do **NOT** release my PHI to:

Name	Relationship

You may leave a message containing PHI on my:

Phone#: _____ ☐HOME ☐CELL ☐OTHER: _____

Phone#: _____ ☐HOME ☐CELL ☐OTHER: _____

☐ OK to send text message regarding appointments, referrals, prescriptions and billing information

Patient Signature: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

**This authorization is valid for 1 year or until Tumwater Family Practice Clinic receives written revocation from the patient or a new HIPAA form is completed. This form will be retained in your medical record.

Expiration Date: _____/_____/_____ Last updated 07/2021

Patient Name: _____**Date of Birth**: _____

Did you provide us with ALL your insurance information?

Please circle your answers

1. Are you covered by insurance through your employer?	YES	NO
2. Are you insured on a plan by your parent?	YES	NO
3. Are you insured on a plan by your spouse?	YES	NO
4. Are you covered by Medicaid (Apple Health)?	YES	NO
5. Are you covered by Medicare Part B?	YES	NO
6. Are you covered by any Federal plans?	YES	NO
7. Are you insured by any other medical coverage?	YES	NO

If you answered YES to any of the questions above, you are required to provide our office with the billing information for that insurance before you will be seen by our providers.

You can NOT choose which of your insurance plans you want to use for your services. You must provide us information on all of your insurance plans and we will confirm the order in which they will need to be billed. **This is an insurance industry requirement not a Tumwater Family Practice Clinic policy. We cannot make any exceptions to this requirement.**

Insurance plans continuously investigate their insured members to check for other health insurance. If you do not provide complete information to all of your insurance companies and to all of your providers, the insurance(s) may initially pay for services but they can take their money back months to years later when they find out you had other insurance coverage. You will be responsible for the balance in this case.

Failure to disclose all of your insurance plans is considered fraud and may result in you being responsible for the entire balance of services rendered and being discharged as a patient from Tumwater Family Practice Clinic.

I acknowledge that I have provided accurate answers to the questions above and understand that if I fail to provide complete information for all of my insurance plans that I am responsible for the balances due. I agree to immediately provide Tumwater Family Practice Clinic with updated information if any of my insurance plans change or any of the answers to the questions above changes at any time during my care.

Patient/Guardian Signature: _____

Printed Name: _____ **Date:**_____

Patient Name: _____ DOB: _____

TFPC Consent for Prescription History

As your Primary Care we feel it is necessary to have available a complete record of your medications prescribed not only by this office, but by other offices or providers. Having your complete medication records is necessary to ensure that when we are prescribing, we are aware of any possible medication interactions or side effects that could occur. In addition, it can help explain certain symptoms you may be experiencing. In order for us to access the pharmacy for your complete medication list, we do need to have your consent. Thank you for your cooperation.

Please complete the following:

I authorize TFPC Clinical Staff to view my prescription history from any/all external sources.

☐ Yes ☐ No

I understand that I have that right to refuse this request. If I refuse, I understand that TFPC may discontinue my care due to incomplete medical information necessary to provide good and proper health care.

Signed: _____

Printed name: _____ Date: _____

Patient Name: _____ DOB: _____

TUMWATER FAMILY PRACTICE CLINIC
Financial Policy

Thank you for choosing Tumwater Family Practice Clinic as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage prior to your appointment.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Any payment made at the time of service is an estimated charge. If the prices for services are not available at the time of service, these will be included in a statement.

3. Communication based technology services. Telephone and web visits to address medical issues are communication based technology services that we provide to our patients. These services are always initiated by the patient and are only billed if we provide an eligible medical service to that patient. Your signature below provides consent for TFPC to bill for these services.

4. Non-covered services. Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We require this form to be completed yearly. We must obtain a copy of your driver's license and current valid insurance at every visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Continued on next page

7. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

8. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 2 weeks to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you and other patient's better by keeping your regularly scheduled appointment.

10. Payment options. We offer various ways to make payments toward your account. We accept payment by cash, check, VISA, MasterCard, American Express and Discover. We do not accept Care Credit. You can make payments by mail, over the phone or through your online patient portal account. We also offer automatic recurring payments.

Thank you for understanding our payment policy. Please contact our Billing department at 360-754-6367 option 4, if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

_____

Printed name