Family Medicine Clinic

34618 11th Place South
Federal Way, WA 98003

Patient Details

Full Name _____ (*First Middle Last*)

Email _____

Employer Name _____

Mariatal Status Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Gender Male ☐ Female ☐

Date of Birth _____ (*MM/DD/YYYY*)

Address _____

City, State Zip _____

Employer Address _____

City, State Zip _____

Phone *Preferred*

Home _____ ☐

Cell _____ ☐

SSN _____

Spouse Information

Full Name _____ (*First Middle Last*)

Phone _____

Email _____

Employer Name _____

Employer Phone _____

Emergency Contact

Full Name _____ (*First Middle Last*)

Phone _____

May we contact this person in the event of an emergency? Yes ☐ No ☐

Relationship _____

Email _____

Employer Name _____

Insurance Details

Primary

Insurance Name _____

Subscriber Name _____

Subscriber Birth Date _____

ID # / Policy # _____

Group # _____

Secondary

Insurance Name _____

Subscriber Name _____

Subscriber Birth Date _____

ID # / Policy # _____

Group # _____

I agree that all information I have provided is correct to the best of my knowledge and that I will update Family Medicine Clinic if any of the provided information changes.

Printed Name _____

Signature _____

Date _____

Relationship to Patient (if signing as guardian) _____

Family Medicine Clinic

34618 11th Ave S #100 Federal Way, WA 98335
253-336-4462
fmclinic@lengmd.com
www.lengmd.com

Office Policy

Though our primary concern is your healthcare needs, we also need you to be aware of our office policy. It is our desire to have a mutually respectful relationship with our patients. In a sincere effort to maintain patient satisfaction, we work diligently to provide quality healthcare and hope we can avoid discrepancies. Communication with our office is crucial. If you have any billing concerns such as a change or a problem, please call our billing office at 253-336-4512.

Printed Patient Name: _____

All co-pays are due at time of service. A $10 billing fee will be assessed for unpaid co-pays. If you do not have your co-pay at time of visit, simply accept the $10 billing fee on your next statement. Please note: your unpaid copay amount, the billing fee, and your current visit copay total are due in full upon your next appointment.

Our no-show/broken appointment policy is as follows: Failure to cancel a scheduled appointment within 24 hours of the start of the day at 8am, no-showing (abandoning) a scheduled appointment, or arriving more than 30 minutes late to a scheduled appointment will result in a $25 service charge. Situations of repeat no-shows, late cancellations, late arrivals, and other forms of broken appointments will require a nonrefundable $25 deposit to schedule future appointments. We feel this $25 service charge is necessary as a broken appointment denies the opportunity of another patient being provided care. Anytime you are uncertain of your appointments, please call. We will be happy to verify them for you.

Accounts 60 days past due without any record of payment will be delinquent until a payment is made. If we do not receive a payment toward your balance within 60 days, you will be suspended from scheduling any future appointments until a satisfactory payment toward your balance is established. Please note: In some cases, it is the discretion of the office staff to decide a minimum amount due before appointments can be resumed.

Forms of payment accepted: cash, debit/credit cards, money orders, and money grams. Checks are not accepted. There is a $25 charge for each returned check due to insufficient funds. The combined amount of the written check amount and the $25 NSF fee is expected before future appointments are allowed.

We do not bill for cash paying patients. We know our cash fee schedule is very reasonable as we understand a lack of insurance can complicate medical needs. The set cash amount is due at appointment check-in. If you do not have your payment at time of visit a $10 billing fee will be assessed.

It is your responsibility to notify us of any demographic changes. If our office is trying to disclose information to you, and your contact information on file with us is incorrect we will hold the patient accountable for any unresolved balances, missed lab follow-ups, etc. that may incur.

We will bill all workers compensation, Labor & Industries, and motor vehicle accident claims with a valid and open claim number. If at any time your claim is closed or denied you are required to pay cash, or your private insurance will be billed.

To expedite your claim processing and keep discrepancies at a minimum, please bring your incident information with you to your appointment or notify the office before your appointment. Failure to have this information available to us may result in paying out of pocket for the visit.

We participate with most insurance plans at the in-network PPO (preferred provider organization) status. If you have questions about your benefit detail for a service or procedure, let our staff know beforehand and we will inquire on your behalf.

It is your responsibility to notify us of any changes in your insurance coverage. Please be aware of the current specifications for your insurance (co-pays, deductibles, etc.). Due to timely filing regulations administered by insurance companies, the sooner you communicate a change or problem the better. If a certain amount of time has elapsed for an outstanding claim requesting subscriber (patient) information the amount of the claim may become patient responsibility.

In the event your insurance does not cover a service or procedure and the claim was submitted correctly you will be responsible for the charge. Legally, we are not permitted to re-submit claims with a new diagnosis or procedure code if the claim was accurately submitted then denied by your insurance company, as this is considered fraudulent and measures are taken against physicians including criminal indictments who code to accommodate coverage.

Please note: We ***do not*** accept DSHS, Molina, or any state issued health plan (all HMO's included). We are a private practice facility with no affiliations with outside organizations. We are not recognized as an in-network preferred facility or provider; therefore, we will maintain our out-of- network classification with these outside organizations. If you are covered under an HMO policy and seek care at our office, you will be responsible for the charges as stated in your HMO benefits plan.

Prescriptions may not be replaced if lost, stolen, misplaced, overused, or abused. All prescription refill requests require 24-48 hours advance notice. Please note: If you call on a Friday your prescription(s) will not be filled until Monday at the earliest, as our office is closed on weekends and this time does not count toward the 24-48 hour time frame.

I have read and understand the office policy.

_____

Patient Signature

_____

Date

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Authorization to Release/Obtain Protected Medical Information

I, _____ _____ _____,
Full Name | Birth Date | Social Security Number

authorize Family Medicine Clinic to release/obtain confidential information to/from the below organization/person.

_____
Person or Organization Releasing/Obtaining

Information to Release
(Check all that apply.)

- ☐ Complete chart notes
- ☐ ER Assessment / Evaluation
- ☐ Physician Orders
- ☐ PT/OT Report(s)
- ☐ Operative Report(s)
- ☐ Lab/Radiology Report(s)
- ☐ Respiratory Report(s)
- ☐ Other: (Please Specify) _____
- ☐ Prescription History
- ☐ Diagnostic Films
- ☐ Immunization Logs

I understand that diagnostic and/or therapeutic information concerning Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted diseases, drug/alcohol abuse, or other health care information classified as protected may be communicated to the individual or organization listed above on the basis of this authorization.

Purpose of Release / to Obtain
(Check all that apply.)

- ☐ To coordinate medical care
- ☐ To meet terms of employment
- ☐ To Transfer to another facility
- ☐ Other: (Please Specify) _____
- ☐ To obtain life insurance
- ☐ To provide information for legal action
- ☐ Payment arrangement
- ☐ To inform friend/relative of treatment procedures

I understand that my records are protected under the Washington State Healthcare Information Act, HIPAA, and applicable federal laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the statutes and/or regulations. I also understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with. My signature below indicates that I have read and understand this authorization and its terms.

_____ _____
Signature | Date

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Consent to Medical Care and Treatment

I authorized Dr. Vuthy Leng and/or Dr. Scott Fox, D.O. and such physicians, associates, assistants and other personnel of the Family Medicine Clinic of Federal Way chosen by him or her to perform the following:

_____

_____ Initial — GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment, which have been described and I have discussed with the doctor.

_____ Initial — SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of specific risks of this treatment protocol/program as described by the doctor which included: Infection, scarring, bleeding, bruising, sepsis, subcutaneous calcification, keloid scar formation, discoloration, pain, regional pain syndrome.

_____ Initial — NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes or risks if no treatment is rendered.

_____ Initial — SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment from another physician.

_____ Initial — OTHER QUESTIONS: I am satisfied with my understanding of the nature of the treatment and all of my additional questions about the treatment have been answered.

_____ Signature

_____ Date

_____ Primary Physician

_____ Time

_____ Phone Number

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E-Prescribing Consent Form

Our office is pleased to announce that we have implemented ePrescribing and we are offering this feature to you. There are benefits to both providers and patients that participate in ePrescribing. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe and secure way, which helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information like drug interactions and prescription History.

Patient benefits:

- Eliminates the possibility of a blurred fax or interrupted transmittals, resulting in delays
- Reduces or eliminates phone calls and call-backs to pharmacies due to questions and clarifications
- Reduced possibility of medical errors
- Less chance of adverse reactions
- Convenience with fewer trips to the pharmacy for drop-offs and pick-ups
- A safer, faster, easier way to get your prescription(s) filled

Printed Patient Name: _____, agree that Family Medicine Clinic of Federal Way may request and use my prescription medication history from other health care providers, insurance payors, and third-party benefit payors for treatment purposes. This consent form will be updated on an annual basis. I understand I am to notify Family Medicine Clinic of Federal Way if my pharmacy information changes.

Pharmacy Information

Primary Pharmacy			
Pharmacy Name		Phone Number	
Address		Fax Number	
Alternate Pharmacy			
Pharmacy Name		Phone Number	
Address		Fax Number	

Patient Signature:_____ Date:_____

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Non-Covered Services Consent Form

Required for the following insurance providers:

- All Regence Oregon Products
- All Regence Washington Products
- Premera Blue Cross (Washington)
- Premera Lifewise (Washington)
- Lifewise of Oregon
- HMA

Printed Patient Name: _____, understands that the services listed below may not be considered eligible for benefits (e.g., services may be determined to not be medically necessary, non-covered or investigational) by my health plan. I understand my health insurance coverage has certain restrictions and limitations such as authorization requirements, and non-covered services and/or supplies.

Services Requested

☐ Hormone Evaluation ☐ Vitamin Testing

Approximate Cost: $_____

YOUR CHOICE – Check Only One

☐ I choose to have th if not medically necessary and I will be responsible for payment. service listed above and have my insurance billed, knowing the cost may be declined.

☐ I choose to have the service and pay for it today.

☐ I decline the service.

Signature:_____ Date:_____