Patient Demographics

Date: _________

Patient's name: _____________________ First name used: _____________ DOB:_________

Sex assigned at birth: ___________ gender identity: _____________ pronouns: ___________

Race: _________________☐ prefer not to say. Ethnicity: __________☐ prefer not to say

Marital status: _______________________

Address:____

City: ________________________ State: ____ Zip: _________

Ph:(_____)_______________ Is it ok to send automated texts and voicemails? Yes or no

Email: _______________________________

Person responsible/guardian (if not the patient):

Name: ______________________________ Relationship to patient: ____________________

Address: ____ Ph: (_____)______________

Email: ________________________________

General Consent to Treat

Welcome to our practice.

At this point in your care, no specific treatment plan has been recommended, until we have had the opportunity to identify your needs. This consent form is simply to obtain your permission to perform the evaluation necessary to identify any condition that might require an appropriate treatment and/or procedures as part of your plan of care. You have the right to be informed about any condition identified and the options for recommended surgical, medical or diagnostic procedure to be used. You may then decide whether or not to undergo any suggested treatment or procedure, after being informed of the potential benefits and risks involved. The practice of medicine is not an exact science and no guarantees have been made to you as to the result of treatment for examinations at Spring Tide Family Health.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. You have the right at any time to ask additional questions or to discontinue or decline services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

Telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) and applicable state privacy laws.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents

______________________________	______________________________
Patient name (Printed)	Patient date of birth
______________________________	__________
Signature of patient/parent/legal representative	Date
______________________________	______________________________
Name of person signing (printed)	Relationship to patient

2619 Cherry St. Hoquiam, WA 98550
Ph: 360-209-4135, F: 833-975-0901

Financial Responsibility p1

We are committed to providing you with the best possible care, and we are pleased to discuss our policies related to insurance and fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility. The following is our policy for accepting insurance and procedures for payment in the event that you no longer have insurance coverage including Medicaid coverage.

By understanding your insurance coverage, you can help your doctor recommend care that is covered in your plan. Spring Tide, PLLC will try to be familiar with your insurance coverage so we can provide you with covered care. However, there are so many different insurance plans that it's not possible for your doctor or our staff to know the specific details of each plan

In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy. Insurance companies determine what tests, therapies and services they will cover. Your insurance company's choices may mean that the test, therapy or service you need isn't covered by your policy.

Financial Agreement

- I agree to assume full, primary responsibility for payment of all charges for services I receive from Spring Tide, PLLC, if not paid by my insurance company or other party. I give permission to the Spring Tide, PLLC and its agents to disclose my protected health information and billing information to my insurance company or others as necessary to obtain payment for services, including confidential HIV-related and alcohol/substance abuse related information.
- I agree to pay any amount of money I owe for the services within 30 days after I receive a bill.

Assignment of Benefits

- I assign to Spring Tide, PLLC any monies and benefits payable to me under any health insurance or other insurance policy, governmental program, or other party providing benefits for all or a part of the services provided.
- I agree that any credit balance after payment from such sources may be applied on any account at Spring Tide, PLLC.
- I certify that the information I have provided regarding my insurance is correct and current. I agree to keep Spring Tide, PLLC informed of any changes in my insurance if and as they may occur.
- I agree to pay Spring Tide, PLLC within 30 days of receiving any payment made directly to me by my insurance company or other party that is connected to charges for services.

- I agree to complete any forms necessary to obtain payment or assignment of such monies or benefits.
- I give permission to Spring Tide, PLLC to request payment for services for no-fault benefits, workers compensation benefits, or any other benefits available to me under any governmental programs for any unpaid balance of my bill. This will be done for me if I am eligible for benefits and do not submit a request for payment of services from these government programs.
- I understand that payment for services rendered is subject to the deductibles, co-pays and in-network/out-of-network benefits specified by my individual insurance policy.

Patient Responsibility

- I understand that in the event that my insurance company pays me directly for services rendered by the practice, I must remit that payment to Spring Tide, PLLC.
- I agree that in the event my insurance coverage changes, I must notify Spring Tide, PLLC of the changes to determine whether Spring Tide, PLLC participates with my new insurance and/or whether services are covered by my insurance.
- I agree that I will bring my insurance card to each session for authorization and verification.
- I understand that I may be assessed a fee of $10.00 if I do not pay my co-payment at the time of service.
- I understand that if I do not pay the patient's responsibility portion of my bill in a timely manner I may be referred to a collection agency as part of a continued collection effort.
- I agree that I shall remain responsible for the payment of my bill even if I am not satisfied with the outcome. I understand that Spring Tide, PLLC does not guarantee any particular outcome.
- I agree that I will provide at least 24 hours notice for appointment cancellations.
- **If an appointment is not canceled or rescheduled at least 24 hours in advance, I agree to pay a $50 late cancellation fee.**

I permit Spring Tide, PLLC to bill my insurance company, if any, for services rendered and to send the necessary reports, including my medical information, for payment of services. I accept financial responsibility for the patient responsibility portion of the fees.

________________________________	_____________________________
Patient name (Printed)	Patient date of birth
____________________________________	___________________
Signature of patient/parent/legal representative	Date
__________________________________	____________________________
Name of person signing (printed)	Relationship to patient

Receipt of Privacy Practices

We maintain a record of the health care services that we have provided to you. We will share this information, as permitted by law, to provide your medical treatment, run our organization, and bill for these services. You have the right to view, obtain a copy, or amend the record if needed.

Our **Notice of Privacy Practices** is available at the front desk and on our website, springtidefamilyhealth.com. It describes in more detail your rights to your health information and how this information may be used and disclosed. Sharing of your health information is typically used to improve the continuity of care that you receive. Common examples include, but are not limited to, the following: sending immunization records to our state registry, use of a Health Information Exchange (HIE) with other health care organizations involved in your care, and accessing your prescription history from pharmacy benefits. If you have questions or want to discuss options for decreased information sharing, please contact us.

By signing below I acknowledge receipt of the Notice of Privacy Practices. This form must be signed by a parent or guardian if the patient is under the age of 18.

With this consent, I also agree that Spring Tide, PLLC may: Call or text the number(s) on file and leave a detailed message for the purpose of treatment, payment or health care operations (TPO). Mail to address(es) on file for the purpose of treatment, payment or health care operations. E-mail to the e-mail address on file for the purpose of TPO.

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