



Grace Clinic
"Passionate about Patient Care"
(509) 326-6474

Registration

Date: _____ First Name: _____ Middle: _____ Last: _____
Home Phone: _____ Cell phone: _____ Work phone: _____
Address: _____ Apartment: _____
City: _____ State: _____ Zip: _____
Birthdate: ____/____/____ Social Security Number: _____ - ____ - _____ Gender: Male [] Female []
Marital status: Single [] Married [] Widowed [] Separated [] Divorced [] Committed []
Nationality: _____ Children: Yes [] No [] Number: _____
Patient employer: _____ Occupation: _____

Insurance

Primary Insurance coverage: _____
Subscriber name (if different than patient) _____
Subscriber # _____ Group# _____
Subscriber social security #: _____ - _____ - _____ Subscriber date of birth: ____/____/____
Secondary Insurance coverage: _____
Subscriber name (if different than patient) _____
Subscriber #: _____ Group #: _____
Subscriber social security #: _____ - _____ - _____ Subscriber date of birth: ____/____/____

Emergency Information

In case of emergency who should we notify? _____
Relationship to yourself: _____ Phone number to contact: _____
Code status: [] Full [] None Comfort [] DNR [] CPR only []

Additional Information

Pharmacy of Choice: _____
How did you hear of Grace Clinic? _____
Are any of your other family members patients here (if so, who)? _____



Grace Clinic
 "Passionate about Patient Care"
 (509) 326-6474

Patient Name (PLEASE PRINT): _____

Insurance Assignment and Release

I, the undersigned have insurance with the _____
 (Name of insurance company)

And assign directly to: Grace Clinic all medical benefits, if any,
 (Name of provider)

otherwise payable directly to me for services rendered. I understand that I am financially responsible whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure payment of the benefits. I authorized the use of this signature on all my insurance submissions.

If "other health insurance" is found in item "9" on the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of my information to the insurer or agency shown. In Medicare assigned cases the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the co-insurance, deductible, or non-covered services. Co-insurance and deductible are determined by charge determination of the Medicare carrier.

 (Signature of insured/guardian) _____ Date

Payment

Uninsured: I agree to be responsible for payment on all charges for services rendered by Grace Clinic providers with **full payment on the day of service.**

Copayment/co-insurance: If I arrive without my visit co-pay I will not be seen and will be asked to reschedule my appointment. I also understand my insurance may assess a co-insurance charge and that it is my responsibility to pay this.

 (Signature) _____ Date

Notice of Privacy Practices Acknowledgement

When you are a patient of this clinic a record of all health care services provided to you is kept. You may ask to see a copy of that record and you may ask for a correction to be made of that record. We will not disclose your records to any other person or clinic without your consent unless we are compelled or authorized by law to do so. You may view your records or obtain a copy of them by contacting office manager.

The Notice of Privacy Practices describes in detail how health information regarding you may be disclosed or used and how you may obtain access to your records.

[] I decline the complete Notice of Privacy Practices forms but acknowledge that I may review it at any time if I so request.

My signature below acknowledges that I was offered the complete Notice of Privacy Practices.

 Parent or legally authorized individual signature _____ Date

Patient Name (PLEASE PRINT): _____

Contact Information

Preferred contact number (please select only one): home [] work [] cell []

Is there anyone else we can talk to other than yourself about your medical care? [] Yes [] No
 If yes, whom?

Patient Signature

Date

Appointment Process

While we make every effort to address each patient's concerns, we are limited by the amount of time available per appointment. Because of this, there may be times when your provider cannot cover every concern you have. Please let the staff know when you schedule, **exactly** what you are scheduling for so appropriate time can be given. If there are additional concerns you may be required to schedule additional visits. This makes the best use of your time and the provider's time as well as conforms to what your insurance company will allow per visit.

It is the office policy that if you fail to show up for your first appointment without canceling with proper notice, you will be *dismissed from the practice and not allowed to reschedule*, as well as being *charged a \$50 no-show fee*. This fee is not billable to insurance and is your responsibility to pay upon receipt of an invoice.

All appointments are confirmed 48 hours in advance. If we are unable to reach you to confirm, please call the office back within 24 hours of your appointment. If it is less than 24 hours until your appointment and we have not had confirmation from you, your appointment will be cancelled.

It is our policy that if you are unable to keep a scheduled appointment that you call to let us know 24 hours in advance. We have an answering machine to take your calls if you find that you need to cancel after hours. Last minute emergencies are a part of life and they will be considered on a patient-by-patient basis.

Barring any unusual circumstances, if you fail to show up for an appointment without canceling ahead of time you will be **accessed a \$25 no-show fee**. _____ int

If you have another no show within 12 months you may be dismissed frm the practice.

If you are late for your appointment without contacting us we reserve the right to reschedule you.

Patient Signature

Date

Patient Name (PLEASE PRINT): _____

Prescription Renewal Process

To streamline the prescription renewal process, we ask that you **please call your refill requests to your chosen pharmacy**. Your pharmacy will fax our office on your behalf. A member of our staff will receive the requests and begin the approval process. **Please do not call the office to request refills.**

We will make every effort to take care of your refill the same day; however you must do your part by calling the pharmacist before you are out of your medication. This applies to all prescriptions whether there are refills remaining or not. From the information the pharmacy provides, the Health Care Provider will determine if you need to be seen before refills are given, if there are no refills remaining.

I have read and understand that the standard process is to call for a renewal to my pharmacy, and *not* the office. *I understand it can take up to 24-48hrs to receive approval and I will allow significant time for the refill to be processed before contacting the office.*

Patient Signature

Date

Results

We make every effort to get back to you as soon as possible with lab/diagnostic results, however, this can take up to a week depending on facility turn-around time. We ask that you **do not call the office** for results unless it has been over a week since you had the test performed.

Patient Signature

Date

Calling the Office

Call the office at (509) 326-6474. Information is taken by support staff and is then passed on to the provider. After an answer is received you are called back with a plan. All calls are returned by the end of the business day. **Please do not call multiple times unless there is a change in symptoms.**

Patient Signature

Date

*** We ask that you please refrain from wearing perfume, cologne or scented body lotions to your appointment, if you do, we reserve the right to reschedule you.**



Grace Clinic
 "Passionate about Patient Care"
 (509) 326-6474

Patient Name (PLEASE PRINT): _____

To assist us in providing you the best possible medical care, please complete the following form. If a question does not apply, or the answer is no, please write N/A or none. Answer every question.

Allergies: (Including reaction)

1. _____ (_____)
2. _____ (_____)
3. _____ (_____)
4. _____ (_____)

Medication: (Including over the counter & vitamins- please include dose)

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |
| 10. _____ | 11. _____ | 12. _____ |
| 13. _____ | 14. _____ | 15. _____ |

Current medical diagnosis (i.e. Asthma, Diabetes, etc.):

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

Health Maintenance: Have you had any of these, if so, when?

| | |
|------------------------------|-----------------------------------|
| Colonoscopy: ____/____/____ | Dental Exam: ____/____/____ |
| Cholesterol: ____/____/____ | PSA: ____/____/____ |
| Pap: ____/____/____ | Flu shot: ____/____/____ |
| Mammogram: ____/____/____ | Pneumonia Shot: ____/____/____ |
| EKG: ____/____/____ | Tetanus: ____/____/____ |
| Vision Check: ____/____/____ | TB test (results): ____/____/____ |



Grace Clinic
"Passionate about Patient Care"
(509) 326-6474

ELECTRONIC MAIL/FAX CONSENT FORM

First Name: _____ Middle: _____ Last: _____

Email Address: _____

Fax Number: _____

I, _____, request and authorize Grace Clinic to communicate with me about any aspect of my health and medical care by email/fax.

My signature below denotes that I have read the document, Patient Electronic Communications, and accept the risk of loss of privacy of confidential medical information associated with email/fax communications. I also agree that Grace Clinic shall not be liable for any type of damage or liability arising from or associated with the loss of confidentiality due to email/fax communication. Further, since Grace does not operate or control any service on the internet, I understand that it cannot and does not guarantee that the use of this means of communication will be free from technological difficulties including, but not limited to, loss of messages.

This authorization for communication by means of email/fax is valid until I notify you in writing that I no longer authorize the use of email/faxes to communicate information concerning my health care. I understand that information communicated by email/fax will be incorporated and retained in my legal medical record. Grace also retains the right to terminate email as a communication option if it becomes unduly burdensome or used inappropriately.

Email should ***not*** be used to schedule/cancel appointments, request medication refills or to report urgent matters. It can be a few days before emails are viewed and responded to. Please keep this in mind when using email to communicate with the provider.

Any questions you may have about the appropriateness of email communication should be asked *before* signing.

Signature or patient/guardian: _____

Date: _____

Relationship to patient: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

_____ BD: ____/____/____ SS: _____
(Print name of patient)

Information to be released from:

_____ Name of designated facility or provider

_____ Address

Information to be released to:

Grace Clinic
823 West 7th, Suite 102
Spokane, WA 99204
P: (509) 326-6474
F: (509) 326-2565

WE WOULD APPRECIATE IT IF YOU PLEASE DO NOT FAX RECORDS OVER 20 PAGES IN LENGTH. THANK YOU FOR YOUR CONSIDERATION.

Information to be released:

- The most recent 2 years of pertinent information (x-rays, chart notes, labs and special tests)
 All medical records
 Specific information (please specify) _____

Purpose for which disclosure is being made: (Please check one of the following)

- Attorney Medical provider Insurance Personal

Patient authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for the release of these records.

* Exclude the following information from the records to be released: (please initial)

- Drug/Alcohol abuse/treatment & diagnosis Sexually transmitted diseases
 HIV/AIDS diagnosis/treatment/testing Mental illness or Psychiatric diagnosis/treatment

My Rights:

I understand that I do not have to sign this authorization to receive health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information that I have authorized to be released reaches the noted recipient, that person may re-disclose it, at which time it may no longer be protected under privacy laws.

SIGNATURE: _____ DATE: _____

(Patient, *guardian or *authorized representative)
(* please provide proof of authority to sign on behalf of the patient)

THIS AUTHORIZATION WILL EXPIRE 90 DAYS FROM THE DATE OF SIGNATURE