Bellingham Arthritis & Rheumatology Center

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Patient Name: Mr. /Mrs. /Ms. /Dr. _____
Last First M.I.
Patient SSN _____ Birthdate _____/_____/_____ Age: ____ Sex: M F

Mailing Address: _____

City _____ State: _____ Zip: _____ Email Address_____

Preferred Phone_____ Home Phone_____ Cell Phone_____

Leave detailed message? Y N
Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other _____

Preferred Pharmacy_____

Primary Care Physician_____ Referring Physician_____

Employer: _____ Position: _____ Phone: _____

Spouse/Partner Name_____ Spouse's DOB _____
Spouse Phone _____ Alt Phone _____

Language Preference: _____ Interpreter Needed? Y N

Race: _____ Ethnicity _____

Emergency contact (not living with patient)
Name of relative/friend: _____ Relationship_____
Phone ( ) _____

Health Insurance Information
Primary Insurance Carrier_____ Group #_____

Subscriber Name_____ Employer_____

Insurance ID #_____

Secondary Insurance Carrier_____ Group #_____
Subscriber Name_____ Employer_____
Insurance ID #_____

I certify that the information I have given above is true and correct.

I authorize release of my medical information to my insurance company for claims processing and I assign my insurance benefits to Bellingham Arthritis and Rheumatology Center.

_____ _____

Signature of Patient or Responsible Party *Date*

Notice of Privacy Practices Acknowledgment

Bellingham Arthritis and Rheumatology Center

We keep a record of the health care services we provide you. You may ask to see and copy that record. 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 about it by contacting *our Office Manager, Jessica Delamare.*

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

BELLINGHAM ARTHRITIS AND RHEUMATOLOGY CENTER FINANCIAL POLICY

Thank you for choosing Bellingham Arthritis and Rheumatology Center as your health care provider. We look forward to being of service to you and providing you with quality care. We believe that it is important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following Financial Policy prior to your treatment. Should you have any questions, please feel free to ask our office staff.

- Bellingham Arthritis and Rheumatology Center is contracted with various insurance companies, which may change from time to time. Please check with our office staff to find out if we are contracted with your insurance plan.
- For patients who are insured through non-contracted insurance companies, we will be happy to courtesy bill your insurance company for you one time only. It will be your responsibility to follow up with your insurance company and pay the bill in a timely manner.
- Please present your insurance card at every visit. Failure to present your insurance card may mean you will be billed the services you receive. If you have DSHS, CHPW or Molina, failure to present your Provider One ID card may mean that you will not be seen.
- Your copay is due at the time of your visit.
- Some insurance plans do not cover certain procedures. In such cases you will be asked to sign a waiver agreeing to pay for the visit at the time of service. You may want to call your insurance company in advance of your visit to determine if the service is covered.
- For our private pay patients, we expect payment in full at the time of service.
- If you pay for your services by check and that check is returned for non-sufficient funds (NSF), we will charge an additional $40.00 to your account. If that happens, you will be asked to remit the amount of the check plus the service charge in cash within 10 days. If your account has not been paid in full by then it may be referred for collection action.
- After receiving a statement, failure to make payment or contact with our office within 60 days will begin our collection process on your account. Repeat failure to pay may result in the dismissal from Bellingham Arthritis and Rheumatology Clinic and the assignment of your account to a collection agency.
- When a child of divorced parents is seen, we expect payment from whichever parent accompanies the child. We will not bill ex-spouses or parents who live outside of the area.
- We require 24-hour notice if you are unable to keep your appointment. Failure to appear for your appointment may result in a “no show” charge or dismissal from the practice. Same day cancellations are also considered “failure to appear.”
- If you are having financial difficulty, our office staff will be happy to work with you. You may want to establish a payment plan. If so, we ask that these payments be made as scheduled, each month and on time. We do monitor these accounts, and non-payment may jeopardize your ability to be seen by our physicians.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions.

I HAVE READ AND FULLY UNDERSTAND THE BELLINGHAM ARTHRITIS AND RHEUMATOLOGY CENTER FINANCIAL POLICY.
I AUTHORIZE THE BELLINGHAM ARTHRITIS AND RHEUMATOLOGY CENTER TO RELEASE INFORMATION AND ASSIGN BENEFITS PER CONTRACT/AGREEMENT.

I hereby authorize Bellingham Arthritis and Rheumatology Center to release to my primary and secondary insurance company any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to be paid to the physicians of the Bellingham Arthritis and Rheumatology Center. I hereby agree to full responsibility for all expenses incurred by myself, or minor child, including services not covered by my insurance. I understand that a rebilling fee-finance charge complying with Washington State Law will be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection and /or court costs and reasonable legal fees should this be required. MEDICARE: I understand my provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance and non-covered services.

_____ Date:_____

Signature, Responsible Party

Please Print Full Name: _____

Current Medications List

Name: _____

Date _____

Prescription Medications / Over The Counter / Herbs & Supplements:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

Allergies

B.A.R.C. Health History

History is probably the most important part of a diagnostic evaluation. Certain background information is necessary. Please fill out this worksheet. If you are unsure about something, mark it with a question mark. We will discuss it during your appointment. Thank you.

Patient Name:_____ Age:_____ Date:_____
Reason for today's visit_____

If you have had the following, circle it and note the approximate year when it occurred.

- Stroke
- Seizures
- Psychiatric illness
- Depression
- Eye redness or inflammation
- Iritis
- Radiation treatment of neck or tonsils
- Thyroid disease or goiter
- Pneumonia
- Pleurisy
- Asthma
- Rheumatic fever
- Heart murmur
- Coronary artery disease
- High cholesterol
- History of heart attack
- High blood pressure
- Bleeding disorder
- Melanoma
- Anemia
- Stomach ulcer
- Crohn's disease or ulcerative colitis
- Hepatitis
- Liver disease
- Yellow jaundice
- Kidney disease
- Kidney stone
- Urinary infections
- Diabetes
- Varicose veins
- Phlebitis or blood clot
- Arthritis
- Gout
- Cancer
- Psoriasis
- Positive T.B. skin test
- Tuberculosis
- Lymphoma

Do you have any of the following? (Please circle)

- Weight loss
- Fever
- Chills
- Skin rash
- Hair loss
- Headache
- Dizzy spells
- Trouble with vision
- Dry eyes
- Dry mouth
- Oral ulcers
- Trouble with hearing
- Trouble swallowing
- Irregular heartbeat
- Chest Pain
- Shortness of Breath
- Cough
- Wheezing
- Abdominal Pain
- Indigestion/heartburn
- Change in bowel habits
- Constipation
- Diarrhea
- Trouble urinating
- Genital ulcers
- Ankle Swelling
- Pain in joints
- Stiffness in joints
- Pain in back
- Pain in neck
- Pain in arms
- Pain in legs
- Difficulty sleeping
- Fatigue
- Numbness
- Pins and needles
- Sun sensitivity
- Abnormal bleeding/bruising
- Fingers turn white with cold exposure

(CONTINUED ON NEXT PAGE)

Have you noticed any change in height? Y N

Have you noticed any change in weight? Y N If yes, increase or decrease of _____ lbs?

Are you allergic to any medications? Y N If yes, please list

_____

_____

Have you had any operations? Y N What kind, when and where?

_____

_____

_____

Any other hospitalizations? Y N For what reason, when and where?

_____

_____

_____

Occupation: _____

Health Maintenance:

Immunization History:

Pneumovax (pneumonia shot): No Yes (year given_____)
Shingles: No Yes (year given_____)
Tetanus Booster: No Yes (year last booster _____)
Flu Shot: No Yes (month/year last booster / _____)

Date of last colonoscopy: _____

Past or current tobacco use? Y N If yes, how much? _____ / When Quit_____

Do you drink? Y N If yes, how much? _____

Past or current recreational drug use? Y N

Do you have a family history of any illness such as gout, diabetes, high blood pressure, arthritis, cancer, rheumatoid arthritis, lupus, psoriasis, scleroderma, muscle disease, heart disease, or inflammatory bowel disease? If so, what disease and which member of your family?

_____

_____

_____

FEMALES:

How many pregnancies? ___ Number of miscarriages ___ Any trouble with pregnancies? _____

_____

Date or age of last menstrual period: _____

Date of last Pap: _____

Result: _____

Date of last Mammogram: _____

Result: _____