FINANCIAL POLICY

Thank you for choosing Family Physicians Group as your health care provider. We are committed to your healthcare needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy.

INSURANCE BILLING

You, the patient, have a contract with your insurance carrier. It is *your* responsibility to know your benefits and if we are a provider for your plan. We do not guarantee that your insurance will cover the services rendered. Although we bill your insurance, complete payment is ultimately your responsibility.

We participate in most major health insurance plans. As a courtesy to our patients, we will submit insurance claims to your carrier. Please present your insurance card(s) at the time of each visit. This is a requirement of all our insurance carriers and ensures correct and timely billing on your behalf. If your insurance has not paid within 30 days, we reserve the right to make it your responsibility to follow up with them.

Motor Vehicle Accidents (MVA): Family Physicians Group does not bill for MVA-related visits. Family Physicians Group is happy to treat you for your condition, however payment for treatment as a result of a motor vehicle accident is due at time of service unless you are insured with *Secure Horizons, DSHS "open coupon", Healthy Options or Basic Health Plan.* Please advise the Registration Desk if this is the case so that we can obtain the necessary billing information. At your request, we will provide you with an itemized statement to submit to your auto carrier. Family Physicians Group does not accept Liens for legal cases.

Workers Comp/Labor & Industries Claims: Family Physicians Group does not treat for or bill occupational injury claims. Please advise the Registration Desk if your injury is work-related. However, if you are uncertain whether your injury is the result of a work-related incident, Family Physicians Group will see you for the initial evaluation. If the injury is deemed to be work-related and further treatment is needed after the initial evaluation, we will refer you to an appropriate specialist for follow-up care.

PATIENT BILLING

If you do not have insurance or if it is determined your insurance will not cover your visit, we require a $140.00 **deposit** ($200.00 for new patients) for each visit. You will be billed for the remaining account balance.

You will receive a monthly statement showing itemized charges and the total due on your account. Our policy is to collect all balances due from previous visits prior to your next visit with your provider. Some circumstances may warrant a payment agreement. We will make every effort to work out a mutually acceptable payment plan. Please contact our Business Office to make financial arrangements. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency.

<u>Financial arrangements between the patient and this practice are the responsibility of the Business Office. Physicians are excluded from making any financial arrangements with patients.</u>

Returned Checks: A $20 fee will be assessed to your account for each returned check. This fee and the original check amount must be paid in full with cash, credit card, or money order prior to your next appointment. After receiving two (2) returned checks, Family Physicians Group will no longer accept checks as a method of payment on your account.

Thank you for trusting us with your care. Please feel free to contact the Business Office at (360) 735-3500 if you have any questions about payment options or your financial responsibilities. Family Physicians Group looks forward to serving you.

I have read and understand the terms of this financial policy. I agree to comply with the terms set forth in this policy for services rendered by Family Physicians Group, PS.

Patient's Name (Please Print)____________________________________

Signed____________________________________ **Date**________________

(Patient or Person financially responsible for the bill)

NOTICE OF PRIVACY PRACTICES

Effective Date: March 20, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Who will follow this notice

Family Physicians Group (FPG) respects your privacy. Family Physicians Group staff understands that your personal health information is very sensitive. The staff includes our employees, medical staff and volunteers who work at FPG. We will not disclose your information to others without your written consent , or if the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. (Federal law 45 CFR 164.500 – 528)

Understanding Your Health Record/Information

Each time you visit FPG, a record of your visit is made. The record may include your symptoms, test results, diagnoses, treatment, plan for future care or treatment, health information from other providers, and billing and payment information relating to these services.

Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

How FPG may use or provide your health information.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- FPG may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan
  - accounting, legal, risk management, and insurance services
  - audit functions, including fraud and abuse detection and compliance programs.

Other Disclosures and Uses of Protected Health Information

FPG business associates – FPG provides some services through contracts with business associates. Examples include:

- Some laboratory tests
- A copy service to make copies of your health record

We may provide your health information to our business associates so that they may:

- Provide a service for you
- Bill you, your health plan, or third party payer for services they provided

To protect your health information, we require our business associates to also protect your health information.

Communication with Family or Caregivers - Health professionals, using their best judgment, may provide health information to a person who is involved in your care. This may be a family member, a relative, close personal friend, or any other person you name. We may also provide this information to someone who helps to pay for your care.

Researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

Funeral Directors and medical examiners - consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations - (tissue donation and transplant) or persons who obtain, store, or transplant organs.

Food and Drug Administration (FDA) - relating to problems with food, supplements, and products.

Workers' Compensation Laws—We may provide health information to the extent allowed by law and needed to abide by laws that relate to workers compensation or other similar programs put in place by law.

Public Health and Safety Purposes as Allowed or Required by Law: - We may be required to provide health information about you for public health activities or when needed to prevent a serious threat to health and safety. In general these disclosures are needed to :

- Report reactions to medicine or problems with products
- Notify people of recalls of products and devices they may be using
- prevent or reduce a serious, immediate threat to public health or safety
- to public health or legal authorities
- protect public health and safety
- prevent or control disease, injury, or disability
- report births or deaths.
- Report Suspected Abuse or Neglect to public authorities.

Correctional Institutions - if you are an inmate of a correctional institutions, we may disclose to the facility or its agents health information needed for your health, and the health and safety of other persons.

Law Enforcement - when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

Health and Safety Oversight - We may provide health information to a healthcare oversight agency. These health oversight activities might include: audit, investigations inspections and licensure as needed for the government to monitor the healthcare system, government programs, and compliance with civil rights.

Military – If you are a member of the armed forces, we may release health information about you as required by military authorities.

Lawsuits and Disputes – If you are involved in a lawsuit or dispute, we may provide health information about you as required by state and federal law.

Fund-raising – FPG may contact you as part of a fund-raising effort

Your Health Information Rights

The health and billing records we create and store are the property of Family Physicians Group. The protected health information in it, however, belongs to you. You have a right to:

- receive, a copy of our Notice of Privacy Practice
- view your health information
- submit a written privacy complaint

You also have the right to ask, in writing, for the following:

- a copy of your health information or health record
- amendments or changes to your information
- Ask us to restrict certain uses and disclosures. (FPG will attempt to honor your request, but may not be able to meet all requests.)
- a list of disclosures of your health information. (The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months.)
- ask that your health information be given to you by another means or at another location.
- Cancel prior authorizations to use or disclose health information (Your revocation does not affect information that has already been released or any action taken before request received)

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this notice to tell you how FPG may use or provide our health information and what we do to protect your private information
- Follow the terms of this Notice.
- Tell you if we are not able to agree to or meet your request to review or access our information, change or amend your health information.
- Meet your reasonable requests to communicate with you about your health information in a different way or at a different location.

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

We reserve the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling 360-735-8100 or by visiting one of our offices or by visiting our website at www.familyphysiciansgroup.com

For more information or to Report a Problem

If you have questions, would like more information, or want to report a problem about the handling of your protected health information, you may contact: FPG Privacy Officer at 360-735-8100

If you believe your privacy rights have been violated, you may contact or submit your complaint in writing to the Privacy Officer of Family Physicians Group at 16811 SE McGillivray Blvd, Vancouver, WA 98683. If we cannot resolve your concern, you also have the right to file a written complaint with the Secretary of Department of Health and Human Services: Office of civil Rights, 200 Independence Ave., SW Washington, D.C. 20202. Your treatment will not be affected by any complaints

FAMILY PHYSICIANS GROUP
ADULT HEALTH QUESTIONNAIRE

NAME:____________________ **DATE OF BIRTH**____________ **TODAY'S DATE:**____________

REASON FOR TODAY'S VISIT: List in order of importance to you	**ALLERGIES:** List any allergies to medications and/or foods

MEDICINES: List all medicines, herbs, nutritional supplements

PAST HEALTH:

MEDICAL PROBLEMS	

SURGERIES:			**OTHER HOSPITALIZATIONS:**		
YEAR	REASON	HOSPITAL	YEAR	REASON	HOSPITAL

FAMILY HISTORY: Has any of your family / blood relatives ever had any of the following conditions? *Complete all columns.*

	NO	YES	Relationship to Patient		NO	YES	Relationship to Patient
Heart attack				Obesity			
Stroke				Arthritis			
High blood pressure				Suicide			
Diabetes				Abuse:			
Cancer				Alcohol			
Asthma				Drug			
Hay fever				Physical			
Mental illness				Sexual			
Tuberculosis (TB)				Other			

List below at what age members of your family died and the cause of their deaths.

	Age if Living	Age at time of Death	Cause of Death
Mother			
Father			
Sibling(s)			
Grandmother (Maternal)			
Grandfather (Maternal)			
Grandmother (Paternal)			
Grandfather (Paternal)			

FAMILY PHYSICIANS GROUP
ADULT HEALTH QUESTIONNAIRE

SOCIAL HISTORY

Marital Status: ☐Single ☐Married / Significant Other ☐Separated ☐Divorced ☐Widowed

Number in household:	Number of children:
Religious Preference (or none):	Occupation:

HABITS

DO YOU NOW USE, **OR HAVE YOU EVER USED**, the following:

	NO	YES		NO	YES
Seatbelts			Alcohol		
Caffeine			Street Drugs		
Tobacco					

Do you need assistance for DAILY ACTIVITIES? ☐No ☐Yes If yes, please check from the following needs:
☐Cooking ☐Grocery shopping ☐Dressing ☐Bed ☐Using Toilet ☐Getting up from a chair ☐Taking medications

IMMUNIZATIONS: ☐ Tetanus ☐ Pneumonia ☐ Influenza ☐ Other

HEALTH MAINTENANCE

Have you ever had a: ☐ Colonoscopy ☐ Flex Sigmoidoscopy ☐ Bone Density (Dexa scan) ☐ Hemoccult Card

PERSONAL SAFETY

	NO	YES		NO	YES
Do you live alone?			Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this with your provider?		
Do you have frequent falls?					
Do you have any vision or hearing loss?					
Do you have an Advance Directive and/or Living Will?					
Would you like information on the preparation of these?					

SEX

	NO	YES		NO	YES
Are you sexually active?			Illness related to the Human Immunodeficiency Virus (HIV) such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk for this illness?		
If yes, are you trying for a Pregnancy?					
If not trying for a Pregnancy list contraceptive or barrier method used?					

FEMALES ONLY

	REPRODUCTIVE HISTORY
Age of first period?	Have you ever been pregnant? ☐No ☐Yes
First day of last NORMAL period (LNMP):	Total number of pregnancies? ______
Length of cycle? Days of flow?	a) # Live Births:______ d) # Still Births:______
Periods are: ☐regular ☐irregular	b) # Full Term: ______ e) # Miscarriages / Abortions:______
Maximum # pads / tampons used in 24 hours?	c) # Premature: ______ f) # Ectopic / Tubal:______
Menstrual cramps: ☐none ☐mild ☐moderate ☐severe	
Date of last Pap Smear:______ Normal: ☐Yes ☐No	Last Delivery Date:
Ever had an abnormal Pap Smear? ☐No ☐Yes	Number of children now living?
Date of last mammogram: Normal: ☐Yes ☐No	Are you breastfeeding now? ☐No ☐Yes
Experienced any recent breast pain/tenderness, lumps or nipple discharge? ☐Yes ☐No	

FAMILY PHYSICIANS GROUP
ADULT HEALTH QUESTIONNAIRE

MALES ONLY					
Do you usually get up to urinate during the night? If yes, # of times ____	NO	YES	Have you had any kidney, bladder or prostate infections within the last 12 months?	NO	YES
Do you feel pain or burning with urination?			Do you have any problems emptying your bladder completely?		
Any blood in your urine?			Any difficulty with erection or ejaculation?		
Do you feel burning discharge from penis?			Any testicle pain or swelling?		
Has the force of your urination decreased?			Date of last prostate & rectal exam? ____/____/____		

REVIEW OF SYSTEMS

SYMPTOMS: Do you have concerns or current complaints? *Please complete all columns.*

GENERAL	NO	YES	EYES	NO	YES	EARS, NOSE AND THROAT	NO	YES
Fever			Vision loss			Ringing in the ears		
Chills			Double vision			Ear discharge		
Sweats			Eye irritation			Ear ache		
Loss of appetite			Blurring			Decreased hearing		
Fatigue			Eye pain			Nasal congestion		
Weakness			Eye discharge			Nose bleeds		
Weight loss			Light sensitivity			Runny nose		
Sleep disorder			Other:			Difficulty swallowing		
Other:						Hoarseness		
						Sore throat		
						Other:		
If you answered YES to any of the above questions, please explain below:			If you answered YES to any of the above questions, please explain below:			If you answered YES to any of the above questions, please explain below:		

CARDIOVASCULAR	NO	YES		NO	YES	RESPIRATORY	NO	YES
Near fainting			Swelling of hands or feet			Sleep disturbances due to breathing		
Chest pain or discomfort			Difficulty breathing while lying down			Cough		
Racing/skipping heart beats			Fainting			Shortness of breath		
Fatigue			Leg cramps with exertion			Coughing up blood		
Lightheadedness			Bluish discoloration of lips or nails			Chest		
Shortness of breath with exertion			Weight gain			Chest discomfort		
Palpitations			Other:			Wheezing		
Other:						Excessive sputum		
						Excessive snoring		
						Other:		
If you answered YES to any of the above questions, please explain below:			If you answered YES to any of the above questions, please explain below:			If you answered YES to any of the above questions, please explain below:		

GASTROINTESTINAL (GI)	NO	YES	GENITOURINARY (GU)	NO	YES	MUSCULOSKELETAL	NO	YES
Excessive appetite			Vaginal discharge			Muscle cramps		
Loss of appetite			Blood in urine			Joint pain		
Indigestion			Urinary frequency			Joint swelling		
Vomiting blood			Inability to empty bladder			Presence of joint fluid		
Nausea			Urinary urgency			Back pain		
Vomiting			Kidney pain			Stiffness		
Yellowish skin color			Trouble starting urinary stream			Muscle weakness		
Gas			Painful urination			Arthritis		
Abdominal pain			Night time urination			Gout		
Abdominal bloating			Inability to control bladder			Loss of strength		
Hemorrhoids			Genital sores			Muscle aches		
Diarrhea			Lack of sexual drive			Other:		
Change in bowel habits			Excessive heavy periods					
Constipation			Missed periods					
Dark tarry stools			Unusual urinary color					
Bloody stools			Abnormal vaginal bleeding					
Other:			Pelvic pain					
If you answered YES to any of the above questions, please explain below:			If you answered YES to any of the above questions, please explain below:			If you answered YES to any of the above questions, please explain below:		

FAMILY PHYSICIANS GROUP
ADULT HEALTH QUESTIONNAIRE

DERMATOLOGICAL (SKIN)

	NO	YES		NO	YES
Excessive perspiration			Skin cancer		
Night sweats			Itching		
Suspicious lesions			Changes in color of skin		
Changes in nail beds			Flushing		
Dryness			Rash		
Poor wound healing			Other:		
Unusual hair distribution					

If you answered YES to any of the above questions, please explain below:

PSYCHOLOGICAL

	NO	YES		NO	YES
Sense of great danger			Depression		
Anxiety			Thoughts of violence		
Thoughts of suicide			Frightening visions or sounds		
Mental problems			Other:		

If you answered YES to any of the above questions, please explain below:

ENDOCRINE

	NO	YES		NO	YES
Excessive hunger			Excessive thirst		
Cold intolerance			Weight change		
Heat tolerance			Other:		
Excessive urination					

If you answered YES to any of the above questions, please explain below:

HEMATOLOGIC (BLOOD)

	NO	YES		NO	YES
Enlarged lymph nodes			Abnormal bruising		
Bleeding			Fevers		
Skin discoloration			Other:		

If you answered YES to any of the above questions, please explain below:

NEUROLOGIC

	NO	YES
Difficulty with concentration		
Poor balance		
Headaches		
Disturbances in coordination		
Numbness		
Inability to speak		
Falling down		
Tingling		
Brief paralysis		
Visual disturbances		
Seizures		
Weakness		
Sensation of room spinning		
Tremors		
Fainting		
Excessive daytime sleeping		
Memory loss		
Other		

If you answered YES to any of the above questions, please explain below:

ALLERGY/IMMUNOLOGY

	NO	YES
Persistent infection		
Hives or rash		
Seasonal allergies		
HIV exposure		
Other		

If you answered YES to any of the above questions, please explain below:

Patient Signature ______________________ **Date** ______________

Reviewed by: ______________________ ☐ Scan (.hxrev)