Medicine Naturally
Integrative practice for children and women
922 S Cowley St, Ste 7, Spokane WA 99202
Ph: (509)262-8145 / www.medicine-naturally.com

Patient Registration

Patient's Name: _____ Date: _____

Age: _____ Date of Birth: _____Social Security #:_____ Gender: Female / Male

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (cell):_____ (work):_____

* Please Circle Preferred Phone

* OK to leave messages regarding results, appointments, general communications? Y or N

Email address: _____

* OK to communicate via email? Y / N

Who Should Be Contacted In Case of Emergency?

Name: _____ Relationship: _____

Phone: _____

Address: _____ Email: _____

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Patient Insurance Information

(Please also bring a copy of your insurance card with you)

Name of Insurance Company: _____

Address: _____

City/ St/ Zip: _____

Insc Company Phone Number: _____

Patient Relationship to Subscriber: _____ Subscriber's Soc Sec #: _____

Subscriber's Full Name: _____ Subscriber's DOB: _____

Subscriber's Address: _____

City/ St/ Zip: _____

Subscriber's Phone Number: _____

Subscriber's Employer Name: _____

ID/Policy #: _____ **Group #:** _____ **Co-Pay Amount: $** _____

Guarantor (Person Responsible for Payment): _____

If different than **patient** or **subscriber**, please provide information below. If **same**, please circle which.

Patient Relationship to Guarantor: _____ Guarantor's Soc Sec #: _____

Guarantor's Full Name: _____ Guarantor's DOB: _____

Guarantor's Address: _____

City/ St/ Zip: _____

Guarantor's Phone Number: _____

Guarantor's Employer Name: _____

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Signature Page

Patient's Name: _____

I. Consent for Treatment

I authorize Medicine Naturally and Dr. Monica German to provide ongoing medical care, treatment, and procedures as needed. I understand that no guarantees can or will be made as to results of care, treatment, or medication prescribed. If the patient is a minor, then proxies for medical consent (others who may bring the child in for medical visits) include the following in addition to the parents or legal guardians of the child: _____

II. Financial Agreement

I understand and agree that I am financially responsible for all services provided. As a courtesy, Dr. German will bill my insurance carrier. Regardless of outstanding insurance claims, full payment is due within 60 days of the date of service. Co-pays are due at the time of service. If collection procedures are required, I am responsible for their cost. Some services may not be covered by insurance policies and they remain my responsibility.

III. Assignment of Benefits

I authorize my insurance benefits be paid directly to Medicine Naturally. I certify that all information given in applying for payment under my health insurance plan is correct, and authorize verification of coverage by Dr. German or staff. Photocopy of this authorization shall be considered as effective and valid as the original.

IV. Consent to Release of Information

I authorize Medicine Naturally to release upon request to my insurance carriers or other reimbursing agencies information about my identity, treatment, diagnosis, prognosis, and/or other services rendered including information about substance abuse, HIV/AIDS, or other sexually transmitted or reportable diseases as permitted by law, thus releasing Medicine Naturally and Dr. German and staff of any liability for furnishing such information. I understand that information may be released through electronic or paper media.

V. Notice of Health Information Practices

I acknowledge that I have been provided with access to or a copy of the Notice of Privacy Practices (See Website).

VI. Approved Methods of Communication: (please circle your choices)

I **do/ do not** consent to the leaving of **voice mail** regarding medical results and appointment reminders.

I **do/ do not** consent to the leaving of **e- mail** regarding medical results and the receipt of electronic forms and appointment reminders.

VII. Acknowledgement of Practice Policies:

I hereby acknowledge that I have reviewed or will immediately review the practice policies as posted at www.medicine-naturally.com and agree to abide by these practice policies while under the care of Dr. Monica German. This includes but is not limited to policies on missed appointments, narcotics, terms for termination of care, payment, and more.

VIII. Signature of Patient or Guardian: _____ **Date**: _____

Printed Name: _____

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Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical practitioners provide all patients with a notice that describes how personal health information (PHI) may be used and disclosed as well as patient rights and medical provider duties regarding this information. Please review the following which is provided in compliance with HIPAA.

Treatment

Your personal health information will be used as necessary to provide optimal medical care. Information may be disclosed to other physicians, nurses, or members of the healthcare team.

Payment

Your personal health information may be disclosed in order to bill and receive payment from your insurance carrier, and is sometimes required in advance to pre-certify payment by insurers.

Business Operations

While committed to the highest possible level of privacy, there may be times when your PHI is disclosed to facilitate quality improvement initiatives, or for the purposes of general business operations including billing. Whenever possible, this information will be de-identified.

Appointment Reminders

Your PHI may be minimally disclosed when messages are left reminding you of upcoming appointments.

Release of information to Family or Friends

ONLY with your written or documented verbal permission, your personal health information may be shared with friends or family of your designation, including those who accompany you to appointments or assist in your care.

Legally Required uses and Disclosures

There are cases in which your PHI may be shared without your permission, including reportable diseases, reportable patterns of injury, abuse, or neglect, events such as births and deaths, reactions to medications, for audits, investigations, and licensure, for judicial proceedings, warrants, subpoenas, as well as to avert a serious threat to safety or health.

You Have the Following Rights:

- To request restrictions on certain uses and disclosures, which may or may not be granted
- To receive confidential communications
- To inspect and copy PHI, provided such inspection has not been deemed a danger to your health or the health of others
- To request the amending of PHI should you find it to be incomplete or in error
- To receive an accounting of disclosures of PHI
- To obtain a paper copy of this notice from the practice upon request

Duties of the Practice:

- To maintain the privacy of confidential information and to provide required notices pertaining to same
- To abide by the terms of the current notice in effect
- If terms are changed by practice, revised notice will be sent to you electronically or in paper format

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the practice (and/or) Secretary of the Department of Health and Human Services by writing to: Secretary of DHHS 200 Independent Avenue SW Washington, DC 20201

or

Dr. Monica German, 922 S Cowley St. Ste. 7, Spokane WA 99202

Effective Date January 2012