LAKE WASHINGTON SPORTS & SPINE

PATIENT INFORMATION

Please complete the following form in its entirety

FULL LEGAL NAME	PREFERRED NAME	GENDER	DOB	SSN

HOME ADDRESS	CITY	STATE	ZIP

MAILING ADDRESS	CITY	STATE	ZIP

☐*same as home address*

HOME PHONE	MOBILE PHONE	WORK PHONE

EMAIL

PREFERED FORM OF CONTACT: ☐**HOME** ☐**MOBILE** ☐**WORK** ☐**EMAIL**

MARITAL STATUS: ☐**SINGLE** ☐**MARRIED** ☐**DIVORCED** ☐**WIDOWED** ☐**LEGALLY SEPARATED** ☐**OTHER**

RACE	ETHNICITY	PRIMARY SPOKEN LANGUAGE

EMPLOYMENT: ☐**EMPLOYED** ☐**SELF-EMPLOYED** ☐**UNEMPLOYED** ☐**STUDENT** ☐**RETIRED** ☐**DISABLED**

CURRENT EMPLOYER:_____

EMERGENCY CONTACT	RELATIONSHIP	PHONE

HOW DID YOU HEAR ABOUT US?

☐**PCP** ☐**PHYSICAL THERAPIST** ☐**CHIROPRACTOR** ☐**OTHER SPECIALIST** ☐**FRIEND/FAMILY** ☐**ONLINE**

☐**OTHER**_____

REFERRING PHYSICIAN: NAME/ FACILITY	CITY	PHONE

PRIMARY PHYSICIAN: NAME/ FACILITY	CITY	PHONE

HEALTH INSURANCE:

Please provide a copy of your insurance card to the front desk at check-in

PRIMARY INSURANCE	**SUBSCRIBER'S NAME**	**BIRTHDATE**
ID #	**GROUP #**	**CLAIMS ADDRESS**
SECONDARY INSURANCE	**SUBSCRIBER'S NAME**	**BIRTHDATE**
ID #	**GROUP #**	**CLAIMS ADDRESS**

CLAIM INFORMATION

PLEASE COMPLETE THIS SECTION IF YOUR TREATMENT IS RELATED TO A CLAIM

WE ***do not*** bill 3rd party auto claims. YOU WILL BE RESPONSIBLE FOR PAYMENT AT TIME OF SERVICE

Is your claim open & *active*? ☐ Yes ☐ No Do you have PIP funds available? ☐ Yes ☐ No

CLAIM TYPE: ☐ MOTOR VEHICLE- PIP WORK-RELATED, CHOOSE ☐ STATE L&I ☐ SELF INSURED L&I

DATE OF INJURY	**CLAIM#**	**POLICY#**

INSURANCE COMPANY NAME

ADDRESS	**CITY**	**STATE**	**ZIP**	**TELEPHONE**

ADJUSTER'S/CLAIMS MANAGER'S NAME	**PHONE NUMBER**	**FAX NUMBER**

Briefly describe *how* & *where* injury occurred: (e.g.: driving; on the job; at home, etc.)

By signing below I agree to the following:

The information supplied on this form is accurate and up-to-date to the best of my knowledge.

I have reviewed a copy of the *Lake Washington Sports & Spine* Financial Policy and I agree to the terms and conditions. I allow *Lake Washington Sports & Spine* (Dr. Garrett Hyman and Dr. Gary Chimes) to participate in the treatment of my health. I authorize *Lake Washington Sports & Spine* to release information to my insurance company, my referring/consulting physicians or other health care providers as deemed appropriate.

I hereby authorize my insurance benefits to be paid directly to *Lake Washington Sports & Spine* and acknowledge the release of this information to my insurance company. I understand I am financially responsible for my copay, deductible/ co-insurance and for non-covered services, as well as an additional 9% interest charge for each month a balance is left outstanding on my account after 90 days. I authorize my doctor to act as my agent in helping me obtain payment from the insurance. I agree that I will not withhold or delay payment if my insurance denies payment on any of my charges. I have been informed of the $35 fee on all returned checks per RCW 62A.3 515 + 520.

In the event it should become necessary to involve a collections agency for unpaid balances, I agree that I will be responsible for unpaid balances, collection fees and interest charge of 1% per month that my balance is left outstanding and no payments have been made. Should legal action be filed, I will accept financial responsibility for reasonable attorney fees, filing fees and any other accrued costs will be my responsibility. I am aware of the late cancellation/no-show fees.

I permit a copy of this authorization to be used in place of the original.

Patient/Responsible Party Signature *Date*

Appointment Cancellation Policy

Lake Washington Sports and Spine (**LWSS**) strives to provide excellent care to all of our patients. It is our goal to help restore each patient to their optimal level of physical function. In order to be consistent with this goal, LWSS uses an appointment system that sets aside time for a patient dependent on each individual's current need. When you fail to attend your scheduled appointment or notify us of your inability to keep your appointment by phone at least 24-hours in advance, the time that has been allotted for your visit cannot be used to treat another patient; it is time lost to our office. With that in mind, an Appointment Cancellation Policy has been put into place.

Our policy is as follows:
We require that you give our office **24-hours notice by phone call** in the event that you need to reschedule or cancel your appointment. **For Monday appointments, cancellations must be made by 1:00pm on the Thursday *prior* to your appointment.** This makes it possible to reschedule your appointment efficiently and presents the opportunity for another patient in need to fill your vacancy.

If a patient misses an appointment or does not contact the office 24 business hours in advance to cancel or reschedule an appointment (or by 1:00pm on Thursday for a Monday appointment), the late cancellation fees will be applied as follows:

In Office

- You will be notified of your missed appointment and will incur a **$350 fee**
- Your appointment will be rescheduled at the physician's discretion *after* the fee is paid
- Two or more late arrivals may result in dismissal from the practice

Telehealth

- You will be notified of your missed appointment and will incur a $350 fee
- Your appointment will be rescheduled at the physician's discretion after the fee is paid

If you have any questions regarding this policy, please make our staff aware; we will gladly address any concerns.

I have read and understand the Appointment Cancellation Policy and agree to be bound by its terms. I also understand that LWSS reserves the right to update or amend this notice.

Printed Name	Signature	Date

Authorization to Use or Disclose Protected Health Information

**The Notice of Privacy Practices Policy can be obtained on our website: http://www.lakewass.com/patient-forms.html or at our front desk.*

_____ (Patient initials) **Notice of Privacy Practices:** I acknowledge that I have received Lake Washington Sports and Spine's (LWSS) Notice of Privacy Practices, which describes the ways in which LWSS may use and disclose my healthcare information for treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated in the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in LWSS Notice of Privacy Practices.

_____ (Patient initials) **Release of Information:** I hereby permit LWSS, the physicians and other health professionals involved in my care to release healthcare information for purposes of treatment, payment or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosure to Others (family, friends, attorney):

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number	Info to be Released

Consent to Email for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team and to provide general health reminders/information.

_____ (Patient Initials) If at any time I provide an email at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email from LWSS.

The email that I authorize to receive email messages is _____

-I understand that I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by **Lake Washington Sports & Spine** in reliance on this authorization before it receives my written revocation.

-I may not be able to revoke this authorization if its purpose was to obtain insurance.

-Two ways to revoke this authorization are: fill out a revocation form (a form is available from **LWSS**) or write a letter to **LWSS**

-I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

_____ _____

Patient signature (or legally authorized individual) Date Time

_____ _____

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

MEDICAL RECORDS RELEASE FORM

Please complete this form if you have had any recent testing (X-ray, MRI, labs) or consults with another physician pertinent to your visit with Dr. Hyman or Chimes.

PATIENT NAME	**DATE OF BIRTH**

By signing this form, I hereby authorize _____ **to disclose:**
(OUTSIDE FACILITY, DOCTOR, SOURCE)

☐ All health information

☐ Health information relating to the following treatment or condition(s): _____

_____

☐ Health information for the date(s) _____

☐ Other: _____

_____ _____

Patient/Responsible Party Signature *Date*

Note: This document must be made part of the patient's medical record. A copy of this document is available for the patient upon request

Telehealth Informed Consent for Patients at Home

Patient Name: _____ Date of Birth: _____

Telehealth is a way for you to get health care remotely (at home). Telehealth visits let you and your provider meet by phone, video, web portal, or other technology. This means that you will not be in the same room as your provider.

By talking with your provider, you learn the benefits, risks, and other options for telehealth:

Expected Benefits

- Better access to health care while you are home
- More efficient evaluation and management of your health

Risks and Common Problems

- Equipment or internet failures could result in more time before a diagnosis or treatment
- Poor connection could make it hard for the provider to see how you are doing and advise the right treatment
- It is rare, but your provider may not be able to get to all of your health records
- It is rare, but your records could be shared, intercepted, and/or changed by someone other than your health care provider despite security measures

What to Expect

Personal technology (like Skype, FaceTime, Zoom, or other web apps) can increase risk of a privacy breach. If you can, try to use a private space to talk to your provider.

A note about your visit will be placed in your health record. Telehealth visits may also be recorded as part of your record. Federal and state privacy and security laws apply to any video, photo, and audio files made and stored. Your records may be shared with others who are helping with scheduling or billing.

You may stop the telehealth visit at any time. Your provider may also stop the visit if they are worried about the connection quality or if they believe that you need to be seen in person.

Patient Authorization

Knowing the risks, I am choosing to move forward with a telehealth visit with **Dr. Hyman/Dr. Chimes** (check one). I have been given the chance to ask questions. My questions have been fully answered.

Witness Signature: _____ Date: _____ Time: _____

Patient or Legal Representative Signature: _____Date: _____ Time: _____

Representative's Relationship to Patient: _____

NEW PATIENT MEDICAL HISTORY FORM

Date:_____

Patient Name_____ **Dominant Hand** ☐Right ☐Left ☐Both

Date of Birth_____ **Height:**_____ft_____in **Weight:**_____

Gender: ☐Male☐ Female

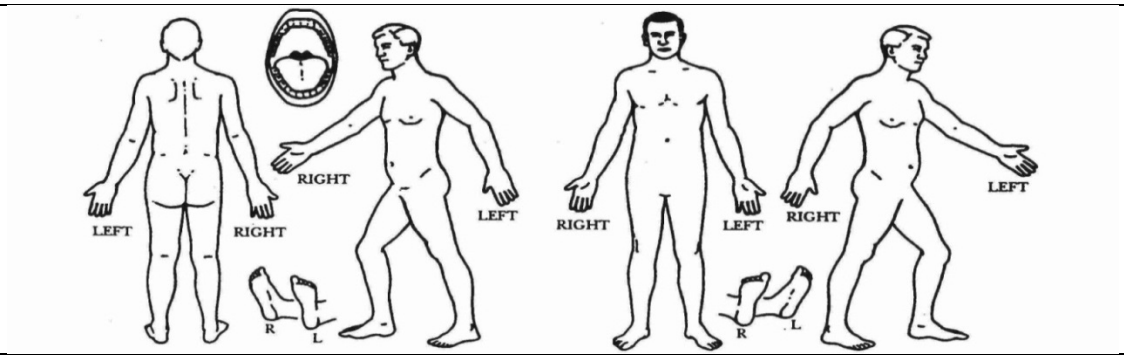
PCP NAME:_____ **Referring Doctor:**_____

***IS THERE ANY OTHER HEALTHCARE PROFESSIONAL TO WHOM YOU WOULD LIKE TODAY'S REPORT SENT?**_____

Exercise History

What is your preferred form of exercise?			
What do you currently do for exercise?			
How many days per week do you exercise?	_____days	**How many minutes per day?**	_____minutes
Intensity	☐ Low ☐ Moderate ☐ Vigorous		
Does your exercise routine currently include:	☐Aerobic Conditioning ☐Strength Training ☐Flexibility/Stretching ☐Balance Training		
Are you currently training for a specific event?			

Symptom History

What is the reason for today's visit? ***Please briefly describe your problem***	
Mark the areas on your body where you typically feel symptoms. ***Include all affected areas.***	
What is your goal for today's visit?	☐ Return to sport_____ ☐ Compete in a specific event,_____ ☐ Play with kids/spouse/pet ☐ Learn more about exercise as a treatment option ☐ Learn more about injections as a treatment option ☐ Clarify my diagnosis ☐ Obtain an ultrasound ☐ Other _____ _____ _____

How long have you been experiencing these symptoms?	Date of onset _____ ☐ _____days ☐ _____weeks ☐ _____months ☐ _____years
Your symptoms are:	☐ Occasional ☐Frequent ☐Constant ☐Worsening ☐Improving ☐Not changing ☐ No pain ☐Mild ☐Moderate ☐Severe ☐Other:_____
Are your symptoms worse:	☐Morning ☐Daytime ☐Nighttime ☐ Varying
Are your symptoms related to any of the following:	☐Sport injury ☐Fall ☐Assault ☐Lifting ☐Twisting ☐Work injury ☐Auto accident ☐Bending ☐Overuse ☐Laceration ☐Trauma ☐Other:_____
What makes your symptoms better? ☐ NONE	☐Sitting ☐Heat ☐Physical Therapy ☐NSAIDs (Aleve, Ibuprofen) ☐Standing ☐Ice ☐Occupational Therapy ☐OTC Medication ☐Lying down ☐Rest ☐Chiropractic care ☐Injection ☐Stretching ☐Massage ☐Counseling ☐Narcotics ☐Position change ☐Orthotics ☐Meditation ☐Other:_____ ☐Limited weight bearing ☐Brace
What makes your symptoms worse? ☐ NONE	☐Sitting ☐Throwing ☐Twisting ☐Going from sit to stand ☐Standing ☐Kicking ☐Bending ☐Walking upstairs/uphill ☐Lying down ☐Running ☐Squatting ☐Walking downstairs/downhill ☐Walking ☐Exercise ☐Pushing/pulling ☐Walking on uneven ground ☐Lifting ☐Jumping ☐Dressing ☐Carrying ☐Landing ☐Getting out of bed **Other**:_____
Associated Symptoms ☐ NONE	☐Weakness ☐Redness ☐Catching/locking ☐Change in bowel/bladder habits ☐Numbness ☐Warmth ☐Popping/clicking ☐Fever ☐Tingling ☐Bruising ☐Buckling ☐Chills ☐Swelling ☐Drainage ☐Grinding ☐Weight loss ☐Radiation down limb ☐Instability
If pain is located in the neck or back does it radiate into your ARMS or LEGS?	☐ Yes, if so which?_____ ☐ No ☐ NOT APPLICABLE
If you have low back pain, please choose which of the following is most limiting to you *(only choose 1):*	☐ Bending over to put on shoes and socks in the morning ☐ Standing in one place for 5 minutes ☐ NOT APPLICABLE ☐Squatting down to pick something up off the floor
Mark the level of pain/discomfort you are having today:	No pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Worst pain ever 0 1 2 3 4 5 6 7 8 9 10
Describe how your symptoms feel: *(check all that apply)*	☐Aching ☐Burning ☐Stabbing ☐Throbbing ☐Sharp ☐Dull ☐Superficial ☐Deep ☐Other:_____
Since your symptoms began, have you experience any of the following?	☐Bowel incontinence ☐Bladder incontinence ☐Anxiety/ Depression related to pain ☐Loss of sleep ☐Progressive limb weakness (worsening) ☐ NONE

Treatment History

Have you had surgery related to your current complaint? ☐Yes ☐No

PROCEDURE	*DATE*	*SURGEON*

Have you had any radiologic imaging or testing related to your current complaint? ☐ **NO**

It is very important that you bring actual films or CD containing the images to your appointment

STUDY TYPE	*BODY PART IMAGED*	*DATE OF STUDY*	*NAME OF FACILITY/HOSPITAL*
X-RAY			
MRI			
CT			
ULTRASOUND			
BONE SCAN			
OTHER			

Have you had an *Electromyography* (*EMG*) or Nerve Conduction Study (NCV) to evaluate nerve function?

☐ Yes ☐ No *If yes, please make arrangements to have the report sent to our office*

Performed on arms/legs/both?	Physician who performed test	Date

Have you had any injections for this problem? ☐ Yes ☐No *Please have the reports sent to our office*

Were the injections helpful? ☐ did not help ☐helped a little ☐helped temporarily ☐helped significantly

NAME OF PHYSICIAN	*INJECTION TYPE, LOCATION*	*DATE OF INJECTION(S)*

Is another physician *currently* prescribing you pain medication? ☐Yes ☐No

NAME OF PHYSICIAN	*LOCATION*	*DATE PRESCRIBED*

Have you *recently* seen any other specialists? ☐ **NO**

NAME AND LOCATION OF PHYSICIAN	*SPECIALTY*	*DATE(S) SEEN*

Have you had any of the following treatments to treat this current problem? ☐ **NO**

TYPE OF SPECIALIST	*DOCTOR/CLINIC NAME*	*DATES (APPROXIMATE)*
PHYSICAL THERAPY		
CHIROPRACTIC		
ACUPUNCTURE		
MASSAGE		
OCCUPATIONAL THERAPY		

Current Medications and Preferred Pharmacy

PHARMACY NAME		
ADDRESS (CITY & ZIP)		
PHONE NUMBER		
NAME OF MEDICATION	*DOSE/ FREQUENCY*	*PRESCRIBING PHYSICIAN*

Allergies *Do you have any known drug allergies?* ☐ Yes ☐ No (*If yes, please list your allergies below*)

NAME OF MEDICATION	*REACTION*		
Are you allergic to any of the following:	Shellfish	☐ Yes	☐ No
	IV contrast dye	☐ Yes	☐ No
Local anesthetics include lidocaine	Local anesthetics	☐ Yes	☐ No
	Latex	☐ Yes	☐ No

Review of Systems *Do you **currently** have any of the following symptoms?* ☐ **NONE**

☐Fever	☐Palpitations	☐Change in appetite	☐Muscle weakness	☐Dizziness	☐Fatigue
☐Weight gain or loss	☐High blood pressure	☐Black stool	☐Joint pain	☐Frequent headaches	☐Increased thirst
☐Vision change	☐Cough	☐Heartburn/reflux	☐Swelling in extremities	☐Anxiety	☐Easy bruising
☐Difficulty hearing	☐Wheezing	☐Urinary frequency/ urgency	☐New rash or psoriasis	☐Depression	☐Excessive bleeding
☐Chest pain	☐Sleep apnea	☐Generalized morning stiffness	☐Numbness or tingling	☐Trouble sleeping	
☐Shortness of breath	☐Nausea/vomiting	☐Muscle aches	☐Seizures	☐Difficulty concentrating	

Medical History *Please check any conditions that apply to you, currently or in the past* ☐ **NONE**

☐Anemia	☐Depression	☐Heart Attack	☐Leg or Foot Ulcers	☐Seizures
☐Anxiety	☐Diabetes	☐Heart Disease, Heart Problems	☐Liver Disease	☐Stroke
☐Arthritis	☐Diverticulitis	☐Hepatitis	☐Lung Disease	☐Tendonitis
☐Asthma	☐Fibromyalgia	☐Hernia	☐Migraines	☐Thyroid Problems
☐Bleeding Disorder	☐Fractures	☐Herniated Disc	☐Osteoporosis	☐Tuberculosis
☐Blood Clots	☐GERD/ Reflux	☐High cholesterol	☐Pacemaker	☐Ulcers
☐COPD	☐Gout	☐High Blood Pressure	☐Peripheral Vascular Disease	☐Urinary Tract Infection
☐Cancer	☐HIV/Aids	☐Hypothyroidism	☐Pulmonary Embolism	☐Vision Loss
☐Coronary Artery Disease	☐Hearing Loss	☐Kidney Disease/ Stones	☐Rheumatoid Arthritis	☐Other:_____ _____

Surgical History *List <u>any</u> surgical procedures you have had* ☐ **NONE**

SURGERY	***DATE (MONTH/YEAR)***	***SURGEON'S NAME***

Family History *List the medical problems of your immediate family (such as diabetes, high blood pressure, heart disease, etc.). If deceased, please indicate cause of death and age.* ☐ **No known conditions**

FATHER	
MOTHER	
SIBLING(S)	
GRANDPARENTS (indicate maternal/ paternal)	

Social History

Are you currently working? ☐ **Yes** ☐ **No**	☐Full Time ☐Part Time ☐Modified/light duty ☐Unemployed ☐ Homemaker ☐ Student ☐ Retired ☐Disabled ☐Receiving workers' compensation payments
What is your job title? **Does your job require lifting?**	_____ ☐ Yes ☐ No **EMPLOYER:**
Please circle the number that corresponds with your current satisfaction with your job:	*0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐* *Completely Dissatisfied* *Completely Satisfied*
If not working, what was your last job? **Last date of work?**	_____ _____
Did you stop working due to your pain?	☐ Yes ☐ No ☐N/A *Is one of your goals to return to work?* ☐ Yes ☐ No
What is your highest level of education?	☐High School ☐GED ☐Vocational Degree ☐Some College ☐College Degree ☐Graduate Degree
What is your marital status?	☐ Single ☐ Married ☐ Divorced ☐ Widower ☐ Other
Do you have children?	☐ Yes ☐ No How many?_____ Ages?_____
Do you use tobacco?	☐ Never ☐ Occasional ☐ Daily: ☐ Cigarettes ____packs/day ☐ Chewing tobacco ___/day ☐ E-cigarette ☐ Cigars ___/day
Do you use alcohol?	☐ Never ☐Rarely ☐Socially ☐Regularly :_____ drinks/day
Do you use marijuana/cannabis?	☐ Never ☐Yes, for pain ☐Yes, for recreation
Who is your favorite musical artist/what is your favorite music genre?	_____

Please answer the following questions by checking "yes" or "no"

☐ Yes ☐ No	Have you used recreational (street) drugs within the past 5 years? (If yes, list below) _____
☐ Yes ☐ No	Do you have any history of recreational or street drug addictions?
☐ Yes ☐ No	Do you have any history of alcohol dependence or alcoholism?
☐ Yes ☐ No	Have you ever been enrolled in a drug or alcohol treatment program?
☐ Yes ☐ No	Do you have any history of prescription drug abuse?
☐ Yes ☐ No	Do you have any history of physical or sexual abuse?
☐ Yes ☐ No	Are you receiving workers compensation or time loss payments?
☐ Yes ☐ No	Are you receiving disability payments?
☐ Yes ☐ No	Have you applied or do you plan to apply for workers compensation or disability?
☐ Yes ☐ No	Do you have a pending lawsuit related to your pain?

I verify that the above information is accurate and complete to the best of my knowledge.

Patient Signature:_____ Date:_____

MD Signature:_____ Date:_____

Lake Washington Sports and Spine

Financial Policy

The providers at Lake Washington Sports and Spine are committed to providing excellent and affordable care to all of our patients. Your understanding of our Financial Policy, and any changes therein, is important to the establishment and continuation of our relationship as Patient and Provider.

1. **Payment for all medical care is the patient's responsibility regardless of insurance coverage.**
2. INSURANCE: We participate in most Blue Cross and Blue Shield plans and we will bill to your insurance if we are contracted and provided with appropriate documentation.
3. CO-PAYMENTS: **All copays are due at the time of service.** A $25.00 fee will be charged to any visit at which a copay is not paid at time of service. It is the responsibility of the patient or responsible party to know if your plan requires a copay.
4. PRIVATE PAY APPOINTMENTS: At the end of your visit, your card will be charged the balance on the visit.
5. ACCOUNT BALANCES: **All account balances must be paid within 30 days of receipt of your billing statement.** Failure to pay your balance owed without contacting our Billing Department will result in a delinquent account. If your account remains unpaid, your account may be turned over to an outside collection agency. Any non-sufficient fund checks will be charged a $25 fee. Accounts in Collections are subject to dismissal from the practice.
6. METHODS OF PAYMENT: We accept Cash and major Credit Cards. Established patients may also pay by Check.
7. LATE CANCEL/MISSED APPOINTMENTS: In fairness to other patients and our providers, we ask for at least 24 hours' notice to cancel appointments. If you arrive more than 5 minutes late for your appointment/arrival time, you may be asked to reschedule to another day. **Late cancel (less than 24 hours' notice) and No-Show appointments incur a $250 fee for telehealth, $350 fee for in-office exams, $350 for procedures other than PRP, Lipogems, or Tenex.** If a patient no-shows multiple times within a 12-monthperiod, s/he and any other family members may be dismissed from the practice. It is your responsibility to attend the appointment or give us 24 hours' notice. A confirmatory reminder is a courtesy.
8. DIVORCE/SEPARATION: In cases of divorce and/or separation, the legal guardian and/or the person bringing the minor patient to the **initial visit** will be held financially responsible for payment of medical services.

Authorization – Payment Card on File

Due to changes in Healthcare Policy and increasing high-deductible Health Insurance plans, we have unfortunately experienced higher numbers of patients with unpaid medical bills. Therefore, we have implemented a new policy in which ***all patients are required to provide a credit card to be kept securely on file for future account balances.***

Please note that this does not change your existing rights with respect to the use of your card. You are still able to ask for investigation into your insurance company's decision on a claim. Card numbers are stored securely off-site with our bank. Card numbers are not kept in our office.

Co-pays will remain due at time of service as part of the contract between patient and insurance company. We will bill your insurance company(s) following your visit. They are required to send us and you a copy of the Explanation of Benefits letter detailing what amount was covered/paid by your insurance, and what, if any, amount is owed by you, the patient. The card on your account will be charged as payment in full for any remaining balance not paid by insurance. You will receive receipts via email as long as we are provided with your email address.

Transactions are run as credit, not debit, and are listed as "Emerald City Sports and Spine Medicine" or "Lake Washington Sports and Spine" on your credit card statement. If you have any questions about this policy, please contact our office by phone at (425)818-0558.

I have read and understand Lake Washington Sports and Spine's Financial and Credit Card Authorization Policy and I agree to its terms as stated.

PATIENT NAME:_____ DATE OF BIRTH: _____

CARDHOLDER NAME: ☐ Same as Patient_____ *Relationship:* _____

LAST 4 DIGITS: _____ CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

CARDHOLDER SIGNATURE:_____ TODAY'S DATE: _____

PLEASE PROVIDE YOUR CREDIT/DEBIT/HSA CARD TO RECEPTION

So we may securely record the entire card number. Thank you!

P (425)818-0558
F (888)557-3062
www.lakewass.com

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