Seattle Menopause Medicine New Patient Demographics and Financial 12/2023

PATIENT INFORMATION

Patient's Legal Name: _____Name you like to be called_____
First Middle Last

Gender: _____ Gender (legal): _____ Gender assigned at birth: _____
Pronouns: he/him, she/her, they/them or _____

Preferred Language: _____

Social Security #_____ Birth Date_____ (Mo/Day/Yr.)

Address _____
Street/ P.O. Box (Apt #) City State Zip Code

Billing Address (if different)
_____
Street/ P.O Box (Apt #) City State Zip Code

Home Phone # (_____) _____Cell # (_____) _____

Email address: _____

Preferred Pharmacy: _____ Cross streets: _____

Guardianship:
If applicable, who has legal guardianship over the patient? Please list name and phone number.

_____

EMERGENCY CONTACT INFORMATION
Emergency Contact/next of kin: _____
(Name and Relationship to patient)
Address_____
City State Zip
Home/Cell Phone # (_____) _____ Work # (_____) _____

With whom may we discuss care:
_____(Initial) SMM may speak to the person indicated below (spouse, family member) about my medical condition. This may include information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine unless specified below.
Name/Relation: _____Phone #: (_____) _____

Authorizations

COMMUNICATION:

_____(Initial) **Allow detailed voicemail messages:**

SMM my leave detailed voice messages at my home #: (_____) _____

SMM my leave detailed voice messages at my cell #: (_____) _____

_____(initial) **Allow text:** SMM may text message me at my cell phone.

_____(initial) **Allow email:** SMM may send my personal health information via email. I understand that email may be unencrypted and that this carries risk of a third-party gaining access. I also understand that emails may be part of my permanent medical record. I also give permission for SMM to communicate via email with my specialists and other outside providers as indicated through my signed release of information form.

_____(initial) **DO NOT ALLOW EMAIL:** I do not wish to have email initiated from SMM; I understand that if I email SMM they may respond to my request via email.

NOTICE OF PRIVACY

_____(initial). I acknowledge that I have had the opportunity to review the Notice of Privacy Practices. This signed acknowledgement form of my review will be retained in my medical record, in accordance with HIPAA Privacy Act regulations. It is also available on our website seattlemenopause.com.

I also acknowledge that SMM may text or call to leave reminder phone calls with date and time, name of provider.

ADUJUNCTIVE TREATMENT:

_____(initial). I understand that SMM is not assuming the role of "primary care provider" rather I am being provided specific care for menopause related symptoms. This may include ongoing care for a specific serve and may require one or several visits. I will be financially responsible for each separate visit.

CONSENT TO BE TREATED:

I give permission and authorize the providers and staff of Seattle Menopause Medicine to examine and treat me. If treatment is for someone else, I am the guardian of, I hereby give permission for the patient to receive treatment. In the rare even that I cannot be reached, I authorize SMM to institute any necessary care for the patient, including hospitalization.

This authorization is in effect until rescinded in writing.

With my signature below, I acknowledge and understand that this information will be kept in my medical record according to and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify SMM should I change one or more of the telephone numbers listed above.

Name of patient: _____ Date of Birth: _____

Signature (patient or guardian): _____Today's date: _____

Seattle Menopause Medicine Financial Policy

Seattle Menopause Medicine (SMM) only accepts payment from patients directly. We require a credit card to be kept on file within our Bluefin Payment Gateway. Credit card information will be collected prior to your first appointment. We do not contract with any insurance product. Even as out of network providers, we cannot work with EPO or HMO plans. In the event you have one of these restrictive plans, they will require you to have an in-network provider. Seattle Menopause Medicine cannot see patients who have Medicaid or Medicare as their insurance provider.

Know your insurance plan.

- Before your visit, call the toll-free number on the back of your insurance card.
- Ask your insurance representative if you have out of network benefits.
- Make sure that you do not have an EPO or HMO plan that prohibits out of network providers.
- If you do not know if your plan is Medicare or Medicaid, please show us your card prior to being seen.

Seattle Menopause Medicine will provide with you an invoice that you can send to your insurance company for reimbursement. We make no guarantee regarding out of network insurance reimbursement or payments. We also are not responsible for further contact with your insurance regarding billing or payments.

For your convenience we accept both Visa and Master Card. We do not accept cash or checks.

SMM collects a deposit of $150 for your first appointment only. We will apply this towards your first visit. We require at least 24-hour notice if you are unable to keep your appointment. Missing an appointment without notice and/or late cancel is considered a no show. Refunds of deposit will be allowed if you cancel prior to 24 hours.

For follow up appointments there is no deposit, however, a $150.00 no show fee may be assessed.

____(initial) I understand that all payments for visits are due at the time of service.
____(initial) I do not have Medicaid or Medicare as my insurance.
____(initial) I have read and understand this policy. A copy will be kept in my chart and may be furnished to me at my request.

Your signature below means that you have read, understand, and agree to all the terms contained in this Financial Policy. All authorizations are in place until rescinded in writing. If you are signing for patients other than yourself, your signature means that you have the authority to act on their behalf and you are financially responsible for services they receive under this Policy.

Patient name: _____ Date of Birth_____

Signature: _____ Today's date: _____

Please print your name here: _____

If signing on behalf of a minor, once the patient reaches 18 years old, they will be asked to sign for themselves.

Credit Card Authorization:

I authorize Seattle Menopause Medicine to charge my credit on file for all charges. These include charges collected for labs, medications, late fees, and other incidentals that will be explained to me prior to any payments being rendered. Credit card numbers will be entered directly by me into the secure payment system Bluefin Payment Gateway within my Patient Portal or by staff through the payment gateway within CharmHealth. No card numbers or bank information is stored in my chart on CharmHealth or in the office and the card number cannot be accessed once entered.

- I can ask and receive a statement of my account which the practice will provide within 5-7 business days.
- Start date of authorization is with the first patient appointment scheduled, when credit card information is entered by me (even if different than today's signature)
- The authorization is in effect until rescinded in writing.

I have read and understand this authorization. A copy will be kept in my chart and a copy may be furnished to me at my request.

Name on credit card: _____

Signature: _____ Today's date: _____