Lacey Medical Clinic
Patient Demographic Information

Patient's Name: ______________________________
Last First Initial

Date of Birth: _____/_____/_____ Gender: Male or Female (please circle)

Social Security #: (optional) ______________________________

Marital Status: Single / Married / Separated / Divorced / Widowed / Child (please circle one)

Address: ______________________________
Street Apt. #

____
City State Zip

Employer/School: ______________________________

Preferred Pharmacy: ______________________________
Name City

Contact Numbers: ______________________________
Home Cell Work

Email: ______________________________

Contact Preference: Home / Cell / Work / E-mail / Mail (please circle one)

Preferred Provider:
- _____ Ronald Krauss, MD
- _____ Ruth Schaffler, ARNP
- _____ Emily Auker, ARNP
- _____ Will Leighty, MD
- _____ Diane Ames, ARNP
- _____ Scott Webster, ARNP, DNP

Ethnicity: ____________________ Preferred Language: ____________________

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

____
Name Address City State, Zip

____
Contact Numbers: Home Cell Work Relationship to Patient

____
Name Address City State, Zip

____
Contact Numbers: Home Cell Work Relationship to Patient

PRIMARY INSURANCE PLAN: ____

Primary Insurance ID #: ____________________ Group Number: __________________

Copay: __________ Insurance Address: ____________________________________

Insurance Plan Phone #: ______________ Subscriber's Employer: __________________

Subscriber's Name: ______________________________ Subscriber's DOB: ___/___/___

Patient relationship to subscriber: Self / Spouse / Child / Other

SECONDARY INSURANCE: ____

Secondary Insurance ID #: ____________________ Group Number: __________________

Copay: __________ Insurance Address: ____________________________________

Insurance Plan Phone #: ______________ Subscriber's Employer: __________________

Subscriber's Name: ______________________________ Subscriber's DOB: ___/___/___

Patient relationship to subscriber: Self / Spouse / Child / Other

I was referred to this office by: ____

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I hereby release insurance payments to be made directly to Lacey Medical Clinic. I am financially responsible for any balance due after insurance. I authorize the doctor or insurance company to release any PHI (Protected Health Information) for treatment, payment or healthcare operations without prior authorization.

____

SIGNATURE OF PATIENT (Parent or Guardian if patient is a minor) **Today's Date**

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank. Thank you for your help.

PATIENT NAME:

____

PATIENT DATE OF BIRTH: ____________ **TODAY'S DATE:** ______________________

MEDICAL HISTORY

Please list any medication/food/environmental allergies or reactions:

____

____

____

Please list all medications, including vitamins, herbal or natural supplements and prescription medications, which you are currently taking. Please note the dosage if possible.

Medication Name & Dosage	*Directions*	*Reason*

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of surgery / reason for hospitalization/ location Date

____

____

____

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____

____

____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

____

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____

When was your last physical?

____

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's name	*Condition they are treating you for*

FAMILY HISTORY

Please check to indicate if you or anyone in your family have ever had the following conditions:

	Self	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Other (please explain)
Alcoholism or Drug Use										
Anxiety										
Asthma										
Cancer										
Cancer Type										
Congestive Heart Failure										
Diabetes										
Depression										
Heart Attack										
Heart Disease										
High blood pressure										
High Cholesterol										
Kidney Disease										
Mental Illness										
Osteoporosis										
Stroke										
Thyroid Disease										
Other										

HEALTH HABITS

Do you smoke or use any tobacco products?......................................_ Yes _ No _ Quit
    Number of cigarettes each day? ___________
    For how many years? ___________________
    Other forms of tobacco used? _____________
Do you drink alcohol?.._ Yes _ No _ Quit
    How much? ______________________
    How often? ______________________
    Have you ever felt that you should cut down on your drinking?................_ Yes _ No
Have you regularly used other drugs?..._ Yes _ No
    If yes, are you still using them?............................ ...._ Yes _ No
Do you exercise? ...._ Yes _ No
    How often? ______________________
    What type of exercise? _________________________

PERSONAL HISTORY

Are you currently married or living with a significant other?................................_ Yes _ No
    Who lives with you at home?___________________________
Are you employed?.._ Yes _ No
    If yes, what kind of work do you do?_________________________________
    If no, is this by choice?___ Disability?____ Other reasons?_______________________
Do you exercise more than 2 times per week?... _ Yes _ No
Do you often feel sad or depressed?.. . _ Yes _ No
Do you feel there is something seriously wrong with your body?......................... _ Yes _ No

SEXUAL HISTORY

Are you sexually active? .... _ Yes _ No
    With: _ Men _ Women _ Both
Do you feel you are at risk for HIV/AIDS? .... _ Yes _ No
Do you have children? .... _ Yes _ No
    How many children do you have? _________
Do you use any form of birth control? .... _ Yes _ No
    If yes, which type / brand? ____

WOMEN ONLY

Have you ever been pregnant? ...._ Yes _ No
    How many times? ___________________
    How many miscarriages? ______________
    How many abortions? _________________
How many children do you have living? _________________________
Do you have menstrual periods? ...._ Yes _ No
    If no, at what age did they stop? ________________
    If yes, are your periods regular? ________________

OTHER COMMENTS:

____
____
____
____
____
____

LACEY MEDICAL CLINIC
PATIENT FINANCIAL AGREEMENT

The following is a statement of our **FINANCIAL POLICY** which we require that you read and sign prior to any treatment. Please understand that the provider-patient relationship is a contractual one; we provide services and in return expect full payment for these services. You, not any other third party, are ultimately responsible for payment for these services.

NON-COVERED SERVICES

I understand that Lacey Medical Clinic contracts with health care insurance plans that relate only to items and services which are "covered" by the health care insurance plans. Accordingly, the undersigned accepts full responsibility for all items or services, which are determined by the health care insurance plans not to be covered in the patient's contract with a health care insurance plan, or in the benefit summary the health care plan furnished to the patient.

ANNUAL PHYSICAL EXAMS

This exam will be billed as **Preventive Care**. You are welcome to discuss specific concerns, your provider may choose to evaluate and treat on the same day as your preventative exam. However, there will be an additional charge for additional services which may result in a copayment or deductible.

SELF-PAY ACCOUNTS

Self-pay accounts are patients who are covered by carriers that the practice does not participate in, or patients who cannot show proof of insurance coverage or patients without an insurance plan (cash pay) at the time of service. The undersigned agrees that I am individually obligated to pay the full charges at the time of service.

All co-payments are due at the time of service. We may ask you to pay a portion of your deductible if you have not yet met your annual deductible at the time of service.

MISSED APPOINTMENTS

Established patients who miss (no show) or cancel without a 24 hour notice may be charged a fee of $50.00. New patients who miss (no show) or cancel without 24 hour notice may be charged a fee of $75.00.

______________________________ ____________________

Signature of Patient or Authorized Party **Date**

Lacey Medical Clinic
5602 Ruddell Rd SE
Lacey, WA 98503
(360) 438-0394

CONTRACT FOR USE OF CONTROLLED SUBSTANCE PRESCRIPTIONS

There are times when your Primary Care Provider (PCP) finds it necessary to prescribe a controlled substance to you for the *short-term* treatment of pain or other problems. Controlled substances are drugs that can cause you to become dependent on them. "Dependent" means you will have withdrawal symptoms. That is why, most of the time your PCP will only prescribe them to you for a short time. Some of these drugs are Codeine, Hydrocodone, Valium, Xanax, Percodan, Stadol, Morphine, Demerol, Darvocet, etc. Because there are dependency problems with these kinds of drugs, we ask you to agree to the following conditions:

1. I am responsible for my controlled substance medications.
2. If the prescription of medication is lost, misplaced or stolen, or if it is used up sooner then the duration prescribed, ***I understand that the medication will not be replaced.***
3. I will keep all medication in a safe place where no one else can get it.
4. I will not give any of my medication to any other person.
5. I will not drink alcohol or use any other non-prescribed mood altering substance while taking this medication(s).
6. I will take all my medication(s) *exactly* as prescribed. I will not increase, suddenly stop, or change the dosage of my medication without the approval of my doctor. If my pain is relieved I may **gradually** take less medication.
7. I must report any stolen medication to the police and supply a copy of a police report for any replacement prescriptions to be considered.
8. I will not request or accept controlled substance medication from any other physician. The only expectations are if I am admitted to a hospital or referred to another physician by my PCP.
9. I will receive controlled substance medication(s) from only one pharmacy.
10. If I notice that I am having an allergic reaction and or I am having symptoms of withdrawal, I will notify my PCP immediately.
11. I will not stockpile (save up) medication and will dispose of any expired medications.
12. ***I will not use any street drugs, like cocaine, crack, marijuana, heroin, etc for any reason.***
13. Refills will be made only during regular office hours in person during a regularly scheduled office visit.
14. Refills will not be made on holidays, weekends or at night.
15. I understand that I must pick up my written controlled substance prescription in person at Lacey Medical Clinic and that phone in refills for controlled substance cannot be made.
16. I will call and allow at least 48 hours ahead for any requested controlled substance refills.
17. Refills will not be made in an "emergency" such as on Friday after hours.
18. I will not go to the Emergency room to get controlled substances.
19. I understand at random drug screens may be requested by my PCP on an unannounced basis.
20. I agree to inform you of any over-the-counter drugs, vitamin supplements, and herbal remedies I am taking.
21. I will not drive or operate motorized equipment after beginning pain medication or after a change (such as a dose increase) until I have assessed the effects of the medication. I will not drive or operate motorized equipment if I ever feel sedated or mentally impaired.

CONTRACT FOR USE OF CONTROLLED SUBSTANCE PRESCRIPTIONS

22. I am aware that the prescription medications are potentially dangerous when not monitored by a physician, and are frequently the target of theft for illegal use. They are also commonly pocketed by curious minors, and others who may be visiting my home. I will be responsible for making sure that my medications are hidden or secured so that they are not an easy target for theft. I will consider using a safe or some other mechanism to lock up my medications.
23. I understand that there are many circumstances in which you may discontinue medication therapy for my condition, including but not limited to interference with functional goals; lack of effectiveness towards improving functional goals, pain, or quality of life; concerns about misuse of medications; inability to appropriately safeguard medications; and failure to follow prescriber instructions.
24. I understand that the clinic has an obligation to notify proper authorities if there is reason to believe illegal activity relating to my medication is taking place, such as diverting the medication to other individuals.
25. I understand that if I violate the terms of this agreement, the violation and your response to the violation will be documented, as well as rationale for changes in the treatment plan.

I UNDERSTAND THAT IF I VIOLATE ANY OF THE CONDITIONS MY PCP MAY STOP MY PRESCRIPTIONS FOR CONTROLLED SUBSTANCES AND MAY START THE PROCESS OF WITHDRAWING ME FROM HIS/HER CARE. If the violation involves obtaining controlled substances from another individual or by forging prescriptions, I may be reported to my primary care physician, local medical facilities and other authorities, including police.

I understand I can speak with my PCP about the psychological and physical dependence (addiction) potential of controlled substances. **All narcotics (like Codeine) and benzodiazepine (like Xanax) drugs create tolerance for dependence.** If I am taking these medications for several weeks, I know that I will develop a tolerance. Then, if I stop taking them all at once, I will have physical symptoms of withdrawal, possibly including tremors, sweats, and nausea and with benzodiazepine, I may also be at risk for a seizure. If I develop tolerance, I know that I must taper such medications gradually and only under medical supervision. Occasionally, a short hospitalization may be necessary in order to discontinue such medication. I agree to comply if my PCP asks me to go into the hospital to withdraw, or detoxify, from the medication(s).

**********I have read the above conditions and agree to abide by them.**********

______________________________ ____________________

Patient Printed Name Date

____

Patient Signature and/or representative

______________________________ ____________________

PCP or other Provider Signature Date

Notice of Privacy Practices Acknowledgment

Lacey Medical Clinic has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Office Manager at 360-438-0394 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Lacey Medical Clinic, P.S.

____

Printed name of patient

____

Patient or legally authorized individual's 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.

For Office Use Only

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: ________________ Staff member initials: ________________

Reasons: ____

____