Welcome To WestSound Orthopaedics!

Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Email Address: _____ May send information here? Yes No
Occupation: _____ SSN: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Work Phone: ( ) _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Years There: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In case of emergency, contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

How did you learn about our practice? _____

SUMMARY OF RIGHTS FOR YOUR MEDICAL INFORMATION

This is a summary of your rights regarding the medical information Franciscan Medical Group maintains about you. See the Notice of Privacy Practices that you received for more information about each of these rights. This summary is provided for your convenience.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your written request to the Medical Record Department at the Franciscan Medical Group Clinic. If you request a copy of the information, we may charge a reasonable fee for costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. To request an amendment, you must submit your written request to the Medical Record Department at the Franciscan Medical Group Clinic. Your request should include a reason that supports your request.

Right to an Accounting of Disclosures. You have the right to receive a list of instances where we have disclosed information for reasons other than treatment, payment or hospital operations or with your authorization. To request this list or accounting of disclosures, you must submit your written request to the Medical Record Department at the Franciscan Medical Group Clinic. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. ***We are not required to agree to your request.*** To request restrictions, you must submit your written request to the Medical Record Department at the Franciscan Medical Group Clinic. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask we only contact you at work or by mail. To request confidential communications, you must submit your written request to the Medical Record Department at the Franciscan Medical Group Clinic.

Right to a Paper Copy of the Notice. You have the right to a paper copy of the Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, **www.fhshealth.org.** To obtain a paper copy please contact the Medical Record Department at the Franciscan Medical Group Clinic.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our administrative office or with the United States Secretary of Department of Health and Human Services. To file a complaint with our facility, please call Risk Management at (253) 552-4116. **You will not be penalized for filing a complaint.**

CHI Franciscan Health

Patient Name: _____
Account #: _____
Date of Service: _____

Notice of Privacy Practices Acknowledgement

In accordance with our Notice of Privacy Practices, you have the right to exercise your Privacy Rights. Those rights are summarized for your review on the back of this page. Contact information is provided below for your help with these rights.

For further information or assistance please contact:

Risk Management
Franciscan Medical Group
1149 Market Street
Tacoma, WA 98402
(253) 552-4116

Normal business hours: Monday – Friday, 8:00 a.m. – 4:30 p.m.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Franciscan Health System Notice of Privacy Practices dated March 2009

_____	_____	_____
Patient Signature (or representative)	**Date**	**Relationship to Patient**

In the event the patient or personal representative of the patient did not sign the acknowledgement, check mark (√) one of the reasons below:

- ☐ Emergency Treatment Situation
- ☐ Individual unable to sign because of medical condition and personal representative is not available.
- ☐ Individual refused. Reason: _____
- ☐ Other (Please explain): _____

_____ Witness

_____ Date

LABEL	**NOTICE OF PRIVACY PRACTICES** **Acknowledgement of Receipt**

CHI Franciscan Health

Our best care. Your best health.℠

FINANCIAL RELEASE: PERMISSION TO BILL INSURANCE:

I, the patient or guarantor, certify that the information provided is true to the best of my knowledge. I accept responsibility for the medical charges incurred by the patient and agree to pay all the bill sat the time of service unless arrangements are made. I authorize Franciscan Medical Group physicians and clinics to release any information to process insurance claims. I also authorize my insurance claim to be paid directly to Franciscan Medical Group.

CONSENT TO MEDICAL TREATMENT:

I consent to x-ray examinations, laboratory tests (including HIV), anesthesia, medical and surgical treatment or other clinic services rendered under the general and special instructions of the physician caring for me. This consent also includes services for any newborn. I recognize that some physicians and/or advanced practice providers furnishing services to me, such as radiology or anesthesia services, are independent contractors and are generally not employees or agents of the clinic. I understand that my care is under the control of my at-tending clinic physicians, and that the contracted physician or advanced practice providers may or may not be covered by my insurance.

I understand that the clinic, as part of its responsibilities and service to the community, participates in many educational programs involving medical, nursing and allied health care occupations, wherein students obtain clinical training and experience in the care of patients. These students are under the instruction and supervision of qualified instructors and/or clinic personnel at all times while attending patients in the clinic. I under-stand that I may be attended and cared for by these students in the course of my daily care and treatment. I understand that photographs, videotapes, digital, or other images may be recorded to document my medical and surgical care, diagnosis and treatment.

In the event a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-born infection during my treatment, I am giving my consent to be tested for HIV. Testing for HIV, Hepatitis B and Hepatitis C will be done at no cost to me, so the healthcare worker can be treated promptly. I authorize release of the information to the exposed healthcare worker, his/her healthcare provider and employee health staff.

COMMUNICATIONS CONSENT:

By providing my cell, landline, or any other number(s), I expressly consent to receiving communications from Hospital, its staff, its contractors, collection agents, and others, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voice mail, text message, using an auto dialer or other computer assisted technology, pre-recorded message(s), or by any other form of electronic communication for any purpose including, but not limited to, appointment and follow-up health care reminders, scheduling, my account(s), assignment of benefits, and/or financial responsibility. I understand that depending on my phone plan I could be charged for these calls or text messages. I agree to provide new number(s) if my number(s) change. Providing these numbers is not a condition of receiving healthcare services.

PATIENT SIGNATURE:

Sign

WestSound Orthopaedics, PS

Name: _____ **DOB:** _____

Surgical History Please list ALL previous surgeries and dates including orthopedic:

_____

_____

Health History Please circle any of the following that you currently have or have had in the past:

Alzheimers	Angina	Anemia	Anxiety	Asthma	Arrythmia
Arthritis	Bleeding disorder	Cancer type____	Cardiac Problems		COPD
Coronary Artery Disease	Depression	Diabetes	Emphysema	Esophageal Reflux	
Glaucoma	Gout	Graves Disease	Heart Attack	Heart Disease	
Hepatitis A,B,C	High Blood Pressure	HIV	High Cholesterol	Hyperthyroidism	
Hypoglycemia	Hypothyroidism	Liver Disease	Lung Disorders	Lupus	
Lyme Disease	MRSA	Multiple Sclerosis	Obesity	Osteoporosis	
Parkinson's	Poly/Fibromyalgia	Pneumonia	Renal Failure	Rheumatoid Arthritis	
Seizures	Sleep Apnea	Strokes/CVA	Ulcers	Vascular Problems/Circulation	

Other: _____

Required Family Medical History (circle one): mother/father/sister/brother/son/daughter

Cancer (type): _____ *Diabetes:* _____ *Cardiovascular:* _____
Mental Illness/Chemical Dependency: _____ *other:* _____

Do you have a family history of bleeding tendencies, blood clotting tendencies, or anesthesia problems? Yes / No

If yes, please describe: _____

Married/Single/Widowed/Partner (circle)

Children? #_____

Employed/Unemployed/Disabled/Retired (circle)

Occupation if Applicable_____

Use of Alcohol: Y / N How many drinks per week? _____ **Use of Tobacco:** Y / N / Previously Quit

☐ Cigars ☐ Cigarettes ☐ Smokeless Amount / Frequency: _____ Duration yrs: _____ Year Quit_____

History of substance abuse/type/year quit:_____

Current Health If you are currently experiencing any of the following problems, please circle them

Constitutional Symptoms	Integumentary	Cardio/Pulmonary	Eyes
Fever	Skin rash / Eczema	Chest Pain	Pain
Chills	Boils	Wheezing	Blurred/Double Vision
Headaches	Persistent Itch	Shortness of Breath	Other:
Other:	Other:		

Ear/Nose/Throat/Mouth	Genitourinary	Musculoskeletal	Endocrine
Ear Infection	Urinary Retention	Joint Pain	Excessive Thirst
Sore Throat	Painful Urination	Back Pain	Too hot/Too Cold
Sinus Problems	Urinary Frequency	Neck Pain	Tired/Sluggish
Other	Urinary Incontinence	Other:	Other:

Hematologic / Lymphatic	Neurological	Allergenic	Gastrointestinal
Swollen Glands	Tremors	Hay Fever	Abdominal Pain
Blood Clotting Problems	Dizzy Spells	Hives	Nausea / Vomiting
Other:	Numbness / Tingling	Other:	Other

Medications please list your current medications and dosage, to include any over the counter:

_____

_____

Medication Allergies/Reaction_____

_____

Latex/nickel allergy(circle)

Pneumonia Vaccination Month/Year_____ **Flu Vaccine Month/Year**_____
Colonoscopy Month/Year_____ **Mammogram Month/Year**_____