

Patient Name (Last,First,MI):			
Address:		Home Phone:	
City:	State:	Zip:	Work Phone:
Social Security #:		Cell Phone:	
Sex:	Date of Birth:	E-mail address:	
Employer:		Occupation:	
Relationship Status (circle one): Single Married/Partnership Divorced Separated Widowed			
Primary Care Physician:		Phone:	

Insurance Information
Primary _____
Secondary _____

Preferred method of contact (circle one):
Email Home Phone Cell Phone letter

Is anyone other than the patient the main policy holder on this insurance?

Yes, Please complete the next box

No, Please continue to Emergency contact person

Policy Holder's Information
Name of insured _____
Relationship to pt _____ Insured birth date ____/____/____
Employed by _____

Emergency Contact Person
Name _____ Relationship _____
Phone # _____

Please sign below the statement if you agree:
IF needed can we contact your primary care provider regarding your care at Lisa Mulligan MD
X _____ date _____

RACE:
American Indian/Alaska Native
Native Hawaiian/Pacific Islander
Asian
Black/African American
Caucasian
Other
Declined

ETHNICITY:
Hispanic/ Latino
Non Hispanic/ Latino
Declined

PERFERRED LANGUAGE:
English
Spanish
Chinese
Korean
Vietnamese
Other _____
Declined

Patient Name:		Date:
Weight:	Height:	Age:

Allergies (non-drug)	yes	no	Difficulty walking	yes	no
Immunization up to date	yes	no	Anxiety or depression	yes	no
Chest discomfort/tightness w/ exercise	yes	no	Bi-polar (manic depressive)	yes	no
Shortness of breath at rest	yes	no	Obsessive Compulsive Disorder	yes	no
Shortness of breath with exercise	yes	no	Chronic cough or lung problems	yes	no
Hard of hearing	yes	no	Chronic cold, bronchitis or pneumonia	yes	no
Chronic heartburn	yes	no	Wheezing	yes	no
Could you be pregnant?	yes	no	Skin problems	yes	no
Problems with urination	yes	no	Excessive bleeding	yes	no
Chronic back problems	yes	no	Unusual fatigue	yes	no

Do you have allergies to medications

NONE

YES (List medication allergies and nature of reaction)

Please list ALL medications you are presently taking, including non-prescription medications such as: *aspirin, antacids, cold or allergy medication.*

Please include all supplements such as fish oil

Medication	Reason

Please indicate if you have or have had any of the following:

History of Asthma	yes	no	Anemia (low blood count)	yes	no
High blood pressure	yes	no	Diabetes, since	yes	no
Heart attack-date	yes	no	Liver disease/Jaundice/Hepatitis	yes	no
Heart failure	yes	no	Kidney Disorder	yes	no
Irregular heart beat	yes	no	Hiatal Hernia	yes	no
Prolapse/Heart murmur	yes	no	Stomach Ulcer	yes	no
Stroke/TIA/Weakness/Paralysis	yes	no	Cancer (type & date)	yes	no
Epilepsy/seizures-Date of last seizure	yes	no	Chemotherapy/Radiation	yes	no

Please list all previous ENT surgeries including wisdom teeth:

Procedure:	Date	Where

Is there any history in your immediate family of:

Do you:

Hearing loss	yes	no	Use street drugs? If yes, list:	yes	no
Bleeding	yes	no	Drink alcoholic beverages?	yes	no
Head/Neck cancer	yes	no	How many drinks per week?		
Allergy/Asthma	yes	no	Current smoker	yes	no
Problems with anesthesia	yes	no	Former smoker	yes	no
			Social smoker	yes	no
			Never smoker	yes	no

INSURANCE INFORMATION

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to my physician. I authorize my physician to release all information required to process my claim. I agree that I am financially responsible for all services provided and should it be necessary to refer the account to collections I will be responsible for all collection fees, collection costs, attorney fees and court costs involved with my account.

Signature _____ date _____

NOTICE OF PRIVACY POLICIES-ACKNOWLEDGMENT

We keep record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our front desk staff.

Signature _____ date _____

FINANCIAL POLICY

Our office is committed to providing quality and cost effective healthcare to our patients. In today's insurance environment it is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us. It is your responsibility to understand the limits and restrictions affecting coverage for services provided by our specialty. If your insurance company requires you to use a specific lab, it is your responsibility to notify us of that. Insurance reimbursement is a contract between you and your insurance company. As a courtesy to you we will file all primary and secondary claims for you. We require a current copy of your insurance card in order to do this and will need to be informed of change in insurance status. You will be responsible for all co-pays, deductibles, and co insurance amounts not covered by a secondary insurance policy along with the entire amount of any non covered service. We appreciate payment for services at the time they are performed. For your convenience we accept cash, personal checks, Visa and MasterCard. We also realize that healthcare is sometimes an unplanned event, so we will attempt to accommodate your personal needs as circumstances require. In order to best meet your needs, please call our billing office at 425-204-6958 with any questions you may have regarding our financial policy and procedures. Patients who do not have insurance coverage or choose to pay for non covered services are expected to pay in full at time of service. If you cannot pay the full amount then you must make satisfactory payment arrangements with our billing office prior to services being rendered.

Signature _____ date _____

AUTHORIZATION TO SHARE HEALTHCARE INFORMATION WITH FRIEND / FAMILY MEMBER

You may share the following health care information with:

Name _____ Relationship _____

Phone number _____

Please check all that apply:

All healthcare information on record

Healthcare information related to following treatment: _____

Other information (appointments, test results, surgery planning, ect.)

Insurance and billing information

Signature _____ date _____

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it.

OVERVIEW – The law states we must obtain your signature confirming receipt of this notice; you may read it at your own convenience.

We recognize our responsibility for safeguarding the privacy of your health information. The law mandates that we provide you with this notice which describes your rights and our obligations for using your health information and informs you about laws that provide special protections for your health information. It also explains how your protected health information is used and how, under certain circumstances, it may be disclosed. It tells you how any changes in this Notice, current effective as of 05/30/03, will be available to you. Questions and complaints regarding our policies can be directed to Amanda Carbone, our acting privacy steward.

Protected Health Information – This Notice applies to health information that identifies you and that relates to your past, present or future physical or mental condition, the care provided or the past, present or future payment for your health care. This information serves as:

A means of communication among the health professionals who contribute to your care;

The legal record describing the care you received;

A means by which you or a third-party payor can verify that services billed were actually provided;

We may use your information to prepare claims for payment for services;

If you have health insurance and we bill your insurance directly, we will have to include information that identifies you, as well as your diagnosis, procedures, and supplies used so we can be compensated for the treatment provided.

However, we will not disclose your health information to a third-party payor without your authorization except when allowed by law; A source of information for public health officials.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION

- Your health information may also be used to contact you (for example, by calling you or sending you a letter) to remind you about appointments, or to provide diagnostic results;
- We provide public health authorities with information on communicable diseases and vital records;
- We provide information to Worker's Compensation agencies and self-insured employers for work-related illness or injuries;
- We provide information to appropriate government agencies when we suspect abuse or neglect;
- We provide information to law enforcement when required or allowed by law;
- We provide information to coroners, medical examiners and funeral directors;
- We disclose information when otherwise required by law, such as Secretary of the United States Department of Health and Human Services for purposes of determining our compliance with our obligations to protect the privacy of your health information.

Disclosure to and Notification of Family, Friends or Others – Unless you object, your health care provider will use his or her professional judgment to provide relevant protected health information to your family member, friend or another person that you indicate has an active interest in your care or the payment for your health care or for notifying these individuals of your location, general condition or death.

Use and Disclosure that Requires your Authorization – Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. If you provide us with written authorization, you may revoke that authorization at any time unless disclosure is required for us to obtain payment for services already provided, we have otherwise relied on the authorization or the law prohibits revocation. Also, in some situations, federal and state laws may provide special protections for certain kinds of protected health information, such as drug or alcohol

treatment records. When required by those laws, we may contact you to receive written authorization to use to disclose that information.

- **Your Individual Rights Regarding Patient Health Information** – You have specific individual rights as to the use and disclosure of your protected health information.
- **The Right to Request Restricted Use:** You may request in writing that we not use or disclose your information for treatment or payment, except when specifically authorized by you, when required by law, or in emergency circumstances.
- We are not legally required to agree to your request.
- **The Right to Receive Confidential Communications:** You have the right to request that we communicate with you about medical matters in a particular way or at a particular location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing.
- **The Right to Inspect and Receive Copies:** In most cases, you have the right to look at or order a copy of your health information.
- **The Right to Request an Amendment to Your Record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we correct the existing information or add the missing information. In your request you must give a reason. We are not required to amend your record, but a copy of your request will be added to your record if you direct us to file it.
- **The Right to Know About Disclosures:** You have the right to receive a list of instances when we have disclosed your health information except in certain instances, such as disclosures for treatment, payment, or health care operations or when you have authorized the use of disclosure. Your first accounting of disclosures in a calendar year is free of charge. Each additional request within the same calendar year will require a processing fee.
- **The Right to Make Complaints:** If you are concerned that we have violated your privacy, you may file a complaint with our office. You may also send a written complaint to the Washington State Department of Health:

Washington State Department of Health
510-4th Avenue West, Suite404
Seattle, WA 98119
Toll Free: 1-800-633-6828

If you believe that your privacy rights have been violated, you may also contact the U.S. Secretary of Health and Human Services; there is no retaliation for filing a complaint.

U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Privacy Notice Changes – We reserve the right to change the privacy practices described in this Notice. We reserve the right to make the revised or changed Notice effective for protected health information we already have as well as any information we may receive in the future. We will have a copy of the current Notice available upon your request.

Lisa Mulligan, M.D.
175 1st Place suite C
Issaquah, WA 98027

425-391-3933