Patient Registration

Angela Heithaus MD | Specializing in Adult ADHD

FirstName:____________________________ Last Name:__________________________________

Street Address:____ City:______________________

State__________ Zip:_______________ email:____

Cell Ph:___________________________ Alt. ph:____

Date of Birth:____________________ Gender: M F SSN:________________________

Referred By: ______________________________________

Auto-pay (optional): cc #______________________ expiration_________ ccv code_______

Primary insurance

Insurance company name:__________________________ Phone:____________________

Subscriber's Name_________________________ DOB:___________ SSN:_______________

Relationship to you:_________________ ID#________________ Group#_____________

Secondary insurance: ____

Patient consent & release

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to Angela Heithaus MD. I authorize the release of any information required to process my claim to the necessary insurance companies, third party payers, and/or other physicians or health care entities required to participate in my care. I agree that I am financially responsible for all services provided.

Initials_______

Financial policy

Our office is committed to providing quality and cost-effective healthcare to our patients. Insurance reimbursement is a contract between you an your insurance company. 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. It is your responsibility to understand the limits and restricts affecting coverage of services you receive. As a courtesy to you we will file all primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and will need to be informed of any change in insurance status. You will be responsible for all co-pay, deductibles and coinsurance amounts not covered by your insurance policy along with the entire amount of any non-covered service. Patient who do not have insurance coverage (or proof of coverage) or who choose to pay for covered services are expected to pay in full at the time of service. For your convenience we accept cash, personal check and all major Credit Cards. If your personal check is returned by the bank due to *Insufficient Funds*, a $50 fee will be charged . Fees will also be assessed for failure to keep scheduled appointments, or failure to cancel with at least 24 hours notice. We realize that healthcare is sometimes an unplanned event, so we will attempt to accommodate your needs as circumstances require . Please call our office at 206 428 2080 with any questions you may have regarding our financial policy and procedures.

Initials_______

I have read and understand the above policies:

Patient Signature ___________________________________ Date: ____________________

Angela Heithaus MD

Missed Appointment/Cancellation’Policy

Phone | Text 206.428.2080 Frontdesk@DrHeithaus.com

Dear Valued Patient,

If you need to cancel or reschedule your appointment we respectfully request tall , text or email at least 24 hours prior to your appointment. This allows sufficient time for otherpatients to be scheduled to see Dr. Heithaus . Cancelled , rescheduled or missed appointments with no notice or with less than 24 hour notice will be charged a $100 fee.

Starting January 1, 2020 the missed appointment /late cancellation fees will be as follows:

* In office 30 minute visit – $150

* In office 60 minute visit $200

* Phone consultation 15 minute – $50

* Phone consultation 20-30 minute – $120

* New patient evaluation (90 minute) – $300

Missed /late Cancellation fees will be charged to your account 48 hours after your scheduled visit. Payment can be made by signing into the PATIENT PORTAL -> Pay My Bill option

I have read and understand Dr. Heithaus' Late Cancellation/Missed Appointment policy

Signature ______________________

Date ______________

In case that you are not able to contact us 24 hours prior to your appointment due to an emergency and would like to discuss these charges please call the office at 206.428.2080.

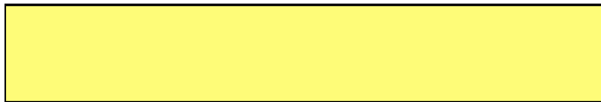
1818 Westlake Ave N Ste 408 Seatte WA 98109

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services that we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose our 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 the provider.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below I acknowledge receipt of the Notice of Privacy Practices:



Patient signature

Date

Printed name if signing on behalf of the Patient

Relationship to Patient (ex. Spouse)

This notice describe how your health information may be used, disclosed and how you can get access to this information. Please carefully review the provided information

The privary of your health information has always important to us and we are commited to protecting it. New federal laws require that we proivde each patient with an official notice of our Privacy Practices.This notice will inform you of ways we use and share your health information, and your rights and our duties regarding the use and disclosure of health information.

The law requires us to:

- Keep your health information private
- Provide you with our Notice of Privacy Practices
- Abide by the terms of the Notice of Privacy Practices currently in effect

We have a right to:

- Change our privacy practices and the terms of this notice at any time, provided that law permits the changes. If we make changes we will update and make available a new Notice of Privacy Practices

Listed here are some of the ways we may use or disclose your information without your specific consent or authorization (this is not a comprehensive listing):
- For Treatment: to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, pharmacists or other healthcare providers who are taking care of you, or to assist them in treating you.
- For Payment: for payment purposes.
- For Health Care Operations: for our health care operations. For example, health information about your may be used to review our treatment and services, and evaluate the performance of our staff in caring for you.
- Other Possible Users and Disclosures:
  * In response to legal proceedings
  * For other healthcare provider' s treatment activities
  * For other covered entities and providers payment activities
  * In case of threat to public health or safety
  * To notify a family member in certain emergency situations
  * To workers' compensation or similar programs for the processing of claims
  * In domestic violence or neglect situations
  * Other uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

The health and billing records we create are the property of this healthcare facility. The health information in it, however, generally belows to you.
You have a right to:
- Request and receive a copy of the most current Notice of Privacy Practices from us
- Look at or receive copies of your health information. You may make this request in writing, using provided forms. We reserve the right to charge a fee for the cost of copying, mailing or other supplices associate with your request.
- Ask us to restrict certain uses and disclosures. You must submit this request in writing. We are not required to grant the request but will comply with any request granted.
- Have us review a denial of access to your health information, with excpetion of certain circumstances

- Ask us to change your health care information. You must submit this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and be included with any release of your records
- Request of list of disclosures of your health information. The list will not include disclosures to third party payors. you may receive this information without charge once every 12 months . We will notify you of the cost involved if you request the information more than once in a 12 month period.
- Ask that your helath information be given to you by other means or at another location. Please sign, date and give us your request in writing. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.
- Cancel a prior authorization to use or disclose health information by diving us a written revocation. Your revocation does not affect any information thta has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.

If you have questions or wish to report a problem you may contact the Privacy Office at 206-428-2080.

If you believe your privacy rights have been violated you may discuss your concerns with any staff member. You may also file a complaint with the Privacy Officer at our practice, or with the US Secretary of Health and Human Services. All complaints must be in writing. You will not be penalized or discriminated against for filing a complaint

CONSENT TO USE ELECTRONIC COMMUNICATIONS

Angela Heithaus MD ("Physician")
1818 Westlake Ave, Suite 408
Seattle WA 98109

frontdesk@drheithaus.com

206.428.2080

The Physician has offered to communicate using the following means of electronic communication ("the Services"):

☒ Email	☒ Tele or video conferencing
☒ Text messaging via 206.428.2080	☒ Website/Portal

PATIENT ACKNOWLEDGMENT AND AGREEMENT:

By typing my name and todays date, I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of th e selected electronic communication Services more fully described in the Appendix to this consent form. I understand and accept the risks ou tlined in the Appendix to this consent form, associated with the use of the Services in communications with the Physician and the P hysician's staff. I consent to the conditions and will follow the instructions outlined in the Appendix , as well as any other conditions that the Physician may impose on communications with patients using the Services.

I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with the Physician or the Physician's staff using the Services may not be encrypted. Despite this, I agree to communicate with the Physician or the Physician's staff using these Services with a full understanding of the risk. I acknowledge that either I or the Physician may, at any time, withdraw the option of communicating electronically through th e Services uponproviding written notice. Any questions I had have been answered.

Patient name:	Date:

APPENDIX

Risks of using electronic communication

The Physician will use reasonable means to protect the security and confidentiality of information sent and received using the Services ("Services" is defined in the attached Consent to use electronic communications). However, because of the risks outlined below, the Physician cannot guarantee the security and confidentiality of electronic communications:

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications can be forwarded, intercepted, circulated, stored,or even changed without the knowledge or permission of the Physician or the patient.
- Even after the sender and recipient have deleted copies of electronic communications back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

If the email or text is used as an e-communication tool, the following are additional risks:

- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

Conditions of using the Services

- While the Physician will attempt to review and respond in a timely fashion to your electronic communication, the Physician cannot guarantee that all electronic communications will be reviewed and responded to within any specific period of time. The Services will not be used for medical emergencies or other time-sensitive matters
- If your electronic communication requires or invites a response from the Physician and you have not received a response within 7 2 hours, it is your responsibility to follow up to determine whether the intended recipient received the electronic communication and when the recipient will respond.
- Electronic communication is not an appropriate substitute for in-person or over-the-telephone communication or clinical examinations You are responsible for following up on the Physician's electronic communication and for scheduling appointments where warranted.
- Electronic communications concerning diagnosis or treatment may be printed or transcribed in full and made part of your medical record. Other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those communications.
- The Physician may forward electronic communications to staff and those involved in the delivery and administration of your care. The Physician might use one or more of the Services to communicate with those involved in your care. The Physician will not forward electronic communications to third parties, including family members, without your prior written consent, ecept as authorized or required by law.
- You and the Physician will not use the Services to communicate sensitive medical information about matters specified below [check all that apply]:

  -Sexually transmitted disease
  -AIDS/HIV
  -Mental health
  -Developmental disability
  -Substance abuse
  -Other (specify):

- You agree to inform the Physician of any types of information you do not want sent via the Services, in addition to those set out above. You can add to or modify the above list at any time by notifying the Physician in writing.
- Some Services might not be used for therapeutic purposes or to communicate clinical information. Where applicable, the use of these Services will be limited to education, information, and administrative purposes.
- The Physician is not responsible for information loss due to technical failures associated with your software or internet service provider.

APPENDIX CONTINUED

Instructions for communication using the Services
To communicate using the Services, you must:

- Reasonably limit or avoid using an employer's or other third party's computer.
- Inform the Physician of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate via the Services.

If the Services include email, instant messaging and/or text messaging, the following applies:

- Include in the message's subject line an appropriate description of the nature of the communication (e.g. " prescription renewal"), and your full name in the body of the message.
- Review all electronic communications to ensure they are clear and that all relevant information is provided before sending to the physician.
- Ensure the Physician is aware when you receive an electronic communication from the Physician, such as by a reply message or allowing "read receipts" to be sent.
- Take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the Physician.
- If you require immediate assistance, or if your condition appears serious or rapidly worsens, you should not rely on the Services. Rather, you should call the Physician's office or take other measures as appropriate, such as going to the nearest Emergency Department or urgent care clinic.