link COMMUNITY CLINIC

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Last Name		First name		Middle Name			
Preferred name		Date of Birth (DOB)		Social Security Number (SSN)			
Marital Status		Race		Ethnicity		Gender	
Street Address		City		State	Zip		
Email Address		Primary Language		Interpreter requested?	☐ Yes ☐ No		
Home phone	Can we leave a detailed voicemail?	☐ Yes ☐ No	Cell Phone	Can we leave a detailed voicemail?	☐ Yes ☐ No	Work Phone	

EMERGENCY CONTACT INFORMATION

Emergency contact Name	Relationship to Patient	
Cell Phone	Home Phone	Work Phone

PRIMARY CARE PROVIDER INFORMATION

Check here if you would like to establish Primary care at Link Community Clinic ☐

Primary Care Provider Name	Facility Name and Number

PHARMACY INFORMATION

Name of Pharmacy		Phone number	
Street Address		City	State	Zip

RESPONSIBLE PARTY INFORMATION ☐ Check here if same as patient

Last Name	First Name	MI	Preferred Name
DOB	SSN	Relationship to Patient	Phone
Street Address		City	State	Zip

PRIMARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number	
Subscriber Name	SSN	Date of Birth	Relationship to Patient

SECONDARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number	
Subscriber's Name	SSN	Date of Birth	Relationship to Patient

CLINIC QUESTION

How did you hear about us? (Check all that apply)

☐ Friend/Family ☐ Social Media ☐ Physician

☐ Walk/Drive By ☐ Internet Search ☐ Other (Please specify) _____

link COMMUNITY CLINIC

NEW PATIENT HEALTH QUESTIONNAIRE

Last Name, First Name (Preferred): _____ **DOB:** _____

For the following three items, check all that apply.

Pronouns ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ not listed _____

Current gender identity ☐ woman ☐ man ☐ transwoman ☐ transman ☐ nonbinary ☐ not listed_____

Sex assigned at birth ☐ male ☐ female ☐ intersex ☐ not listed _____

For the following three tables, if you need additional space, please feel free to use the back of page 3.

Allergies *(Please list all food and drug allergies along with the reaction you experienced.)*

Food or Drug Allergies	Reaction

Medications *(Please list all prescription and over-the-counter medications with their doses and frequency.)*

Medication	Dose	Frequency

Supplements/Vitamins *(Please list all supplements or vitamins with their doses and frequency.)*

Supplement/Vitamin	Dose	Frequency

Menstrual History/Pregnancies *(Please answer all questions to best capabilities, select NA if does not apply.)*

Total Number of pregnancies: N/A☐			
Year of Pregnancy	**Delivery// Abortion //Miscarriage**	**Weeks of Gestation**	**Vaginal or C- Section**

Date of Menarche:	
Start date of last menstrual cycle:	
Any Complications or problems related to cycle:	

Home and environment *(Please check all that apply.)*	
Are you a caregiver?	☐ Yes ☐ No
Do you have any pets?	☐ Yes ☐ No
Are you passively exposed to smoke?	☐ Yes ☐ No
Are there any guns present in your home?	☐ Yes ☐ No

Past and current medical conditions *(Please check or list any medical problems you have experienced).*		
☐ Abnormal Bleeding	☐ COPD	☐ Ear/Hearing Problems
☐ Acid Reflux (GERD)	☐ Cardiomyopathy	☐ Epilepsy/Seizures
☐ AIDS/HIV	☐ Aneurysm	☐ Diabetes
☐ Allergies	☐ Congestive Heart Failure	☐ Fibromyalgia
☐ Anemia	☐ Gastrointestinal Disease	☐ Gestational Diabetes
☐ Headaches	☐ Hepatitis/Liver Disease	☐ High Cholesterol
☐ Hypertension	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Kidney Disease	☐ Mental Illness	☐ Migraines
☐ Neurological Disorder	☐ Neuropathy	☐ Osteoporosis/Osteopenia
☐ PCOS	☐ Pacemaker	☐ Peripheral Vascular Disease
☐ Pulmonary Embolism	☐ Rheumatoid Arthritis	☐ Sleep Apnea
☐ Stroke	☐ Cancer	☐ Eczema
☐ Abnormal Pap Smear	☐ Other _____	

Surgical History/Hospitalizations *(Please note all previous surgeries or hospitalizations and the year they occurred.)*		
☐ Abdominal Surgery	☐ Bilateral Mastectomy	☐ Joint Replacement
☐ Appendectomy	☐ Caesarean Section	☐ Thyroid Surgery
☐ Back Surgery	☐ Cardiovascular Surgery	☐ Tubal Ligation

☐ ENT Surgery	☐ Vasectomy	
☐ Other _____		

Family History *(Please check or list any diseases that run in your immediate family.)*		
☐ Family history unknown		
☐ Heart disease	☐ Diabetes mellitus	☐ Malignant neoplasm of skin
☐ COPD	☐ Disorder of skin	☐ Malignant tumor of breast
☐ Crohn's disease	☐ Disorder of lung	☐ Multiple sclerosis
☐ Depressive disorder	☐ Disorder of thyroid gland	☐ Osteoporosis
Additional family history:		

Over the last two weeks, how often have you been bothered by any of the following problems? *(Please circle)*

	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, hopeless	☐ 0	☐ 1	☐ 2	☐ 3

Health Habits *(Please circle the appropriate answer.)*

Tobacco Use						
Smoking status	I've never smoked ☐	I'm a former smoker ☐	I'm a passive smoker ☐			
	I smoke somedays		I smoke everyday			
How many years have you smoked	< 5 ☐	5-10 ☐	11-15 ☐	16-20 ☐	21-25 ☐	>25 ☐
How many packs per day do you smoke?	¼ ☐	½ ☐	1 ☐	1½ ☐	2 ☐	3 ☐
Have you used e-cigarettes or vape?	Never used ☐	Former user ☐	Current user ☐			
Have you used smokeless tobacco?	Never used ☐	Former user ☐	Current user ☐			
Are you ready to quit?	☐ Yes. ☐ No					

Alcohol Use					
How often do you have an alcoholic drink?	Never ☐	Monthly or less ☐	2-4 times per month ☐	2-3 times per week ☐	4+ times per week ☐
How many alcoholic drinks do you typically drink when you are drinking?	1-2 ☐	3-4 ☐	5-6 ☐	7-9 ☐	10+ ☐

Note the number of each item you drink per week	Glass of wine_____	Cans/bottles of beer_____	Shots of liquor_____
Recreational drug use			
Do you use recreational drugs? ☐ No ☐ Yes (please specify)			
Physical Activity			
How many days in a week do you engage in strenuous physical activity (walking, running, swimming, dancing) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7			
Sexual History			
Are you Sexually Active?	☐ Yes ☐ No		
Partners?	☐ Male ☐ Female ☐ Both ☐ Other _____		
Do you use anything to prevent pregnancy in yourself or your partners?	☐ No ☐ Yes	☐ If yes, what type? _____	

Any Additional Health Information or extension of medication lists can be added here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your time. Your medical history is important to us!

Name: _____ Birth Date: ___/___/___ Date: ___/___/___

REVIEW OF SYSTEMS

Please check any of the following boxes that apply to you NOW.

CONSTITUTIONAL

- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Night sweats
- ☐ Hot flashes
- ☐ N/A

EYES

- ☐ Double vision
- ☐ Vision changes
- ☐ N/A

HEAD/EARS/NOSE/THROAT

- ☐ Headaches
- ☐ Migraines with aura
- ☐ Dizziness
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Nose bleeding
- ☐ Thyroid mass
- ☐ Neck pain
- ☐ N/A

MUSCULOSKELETAL

- ☐ Joint pain or swelling
- ☐ Muscle pain
- ☐ Back pain
- ☐ N/A

RESPIRATORY

- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Spitting up blood
- ☐ N/A

BREAST

- ☐ Lumps
- ☐ Tenderness
- ☐ Swelling
- ☐ Discharge
- ☐ Pain in breast
- ☐ Abnormal changes
- ☐ N/A

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Bloody/black stool
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ N/A

GENITOURNARY

- ☐ Urgency or urination
- ☐ Frequency of urination
- ☐ Pain with urination
- ☐ Nighttime urination
- ☐ Leaking urine with sneeze
- ☐ Blood in urine
- ☐ Decreased sex drive
- ☐ Painful intercourse
- ☐ Possible pregnancy
- ☐ Genital sores
- ☐ STD exposure
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Vaginal odor
- ☐ Vaginal irritation
- ☐ N/A

SKIN

- ☐ Rashes
- ☐ Itching
- ☐ Skin dryness
- ☐ Skin lesions
- ☐ Changes to lesions or moles
- ☐ Acne
- ☐ N/A

ENDOCRINE

- ☐ Loss of hair
- ☐ Difficulty tolerating cold
- ☐ Difficulty tolerating heat
- ☐ N/A

NEUROLOGICAL

- ☐ Muscular weakness
- ☐ Numbness or tingling
- ☐ Difficulty concentrating
- ☐ Memory difficulties
- ☐ Speech difficulties
- ☐ Seizures
- ☐ Loss of balance
- ☐ N/A

HEMATOLOGIC/LYMPHATIC

- ☐ Bruises, frequently or easily
- ☐ Cuts do not stop bleeding
- ☐ Enlarged lymph nodes
- ☐ N/A

PSYCHIATRIC

- ☐ Premenstrual syndrome (PMS)
- ☐ Anxiety
- ☐ Depression
- ☐ Impulsive behavior
- ☐ Suicidal thoughts
- ☐ Excessive anger
- ☐ Mood swings
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ N/A

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Irregular heartbeats
- ☐ Rapid heart rate
- ☐ Fainting
- ☐ Swelling of legs
- ☐ Varicose veins
- ☐ N/A

ALLERGIC/IMMUNOLOGIC

- ☐ Frequent illness
- ☐ Seasonal allergies
- ☐ N/A

Last Menstrual period ___ /___ /___

OTHER

1) International travel this year? _____

2) Fall risk? _____

_____

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COMMUNITY CLINIC

Please review the following terms of agreement.

1. HIPAA Agreement

I hereby authorize Link Community Clinic and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that I have a right to revoke this authorization by providing written notice to Link Community Clinic, PLLC. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

2. Treatment Consent

I am seeking medical care at Link Community Clinic and give permission to the medical staff to examine me, make diagnoses, and provide treatment in accordance with the explanations and recommendations provided.

3. Financial Consent

By signing this form, I understand

- that if I do not have medical insurance, I am responsible for all charges incurred and that I will pay or agree to be billed for any outstanding balances in accordance with the billing policy.
- that if my insurance is accepted, I authorize payment of benefits or agree to reimburse if I am paid directly by my carrier.
- and authorize information concerning my illness and treatment to be transferred to my insurance carrier(s) in accordance with its privacy policy.

- that any tests (blood work or otherwise) sent to an outside facility will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the facility.
- that my insurance may not cover all charges deemed medically necessary.
- that I am responsible for any part of the charges that are not covered by my insurance, and I will be billed directly for those services.

By signing the form below, I understand that Link Community Clinic has its own late cancellation and no-show policies as follows:

- Any appointment cancelled in less than 24 hours prior to the appointment is defined as a late cancellation.
- After one late cancellation or no-show, a reminder will be sent about Link Clinic's late cancellation and no-show policies.
- After one or more late cancellation or no-show, an amount of $50 will be charged to the account for each appointment missed.

By signing the form below, I understand that Link Community Clinic has an after-hours phone line in the case of an urgent need and that the charges for this service is time-based defined as follows:

- $30 for 5-10 minutes of consultation and management.
- $50 for 10-20 minutes of consultation and management.
- $80 for 20-30 minutes of consultation and management.

4. Telemedicine Consent

I have chosen to receive care through the use of telemedicine. Telemedicine enables health care providers at different locations to provide safe, effective, and convenient care through the use of technology. As with any health care service, there are risks associated with the use of telemedicine, including equipment failure, poor image resolution and information security issues.

This agreement is intended as a supplement to the general consent to treatment and does not amend the general consent. The laws of confidentiality apply to telemedicine visits and no recording or screen capture of any kind is to be used, by provider or by patient, during a telemedicine visit.

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COMMUNITY CLINIC

OFFICE POLICIES CONSENT

HIPAA, Treatment, Financial, Telemedicine

Providing your signature below acknowledges you have read, understand, and agree to the terms above.

Patient Name: _____ Date of Birth: _____

Representative's Name/Relationship (if other than patient): _____

Signature: _____ Date: _____

Translator's Name (if applicable): _____

Translator Signature: _____ Date: _____

107 N Tacoma Ave
Tacoma, WA 98403
P: (253) 267-1317
F: (833) 567-0752

Authorization to Release Personal Health Information

Individual Information		
Last Name:	First Name:	Date of Birth:

Information may be disclosed by:		
Name of provider/organization releasing information:		
Address:		Suite #:
City:	State:	Zip:
Fax:	Phone:	

Information may be disclosed to:		
Name of organization or person to receive information: LINK COMMUNITY CLINIC		
Address: 107 N. TACOMA AVE		Suite #:
City: TACOMA	State: WA	Zip: 98403
Phone: 253.267.1317	Fax: 253.212.3128	

Information to be disclosed:

☐ All records from the last 2 years of visit

☐ Information from date: ____ /____ /____ to date ____ /____ /____

☐ Specific information: _____

☐ Other: _____

Reason for disclosing health information

☐ Attorney ☐ Insurance ☐ Doctor ☐ Medical Leave ☐ Personal ☐ Other _____

Authorization: Unless otherwise indicated, I authorize sensitive information about my conditions which may include sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include sensitive information about behavioral or mental health services and treatment for alcohol or drug abuse. Please initial here if you agree to authorize the release of sensitive information: _____

☐ **Please check this box if you do not wish us to include sensitive information**

Rights

I may revoke this authorization in writing. Once the information I have authorized is disclosed, it may no longer be protected under health information privacy laws. If I revoke my authorization, it will not affect any actions already taken by Link Community Clinic, PLLC based upon this authorization.

Signature of Patient of Guardian, or Authorized Representative (documentation may be required to prove authority)	Date:
Minor Signature (required if minor is age 13-17)	Date:

This authorization will expire 90 days from the date signed **or** on the date indicated here: ____ /____ /____

Charges:
There will be no charge if your medical records are sent directly to a health care facility or provider for continuing or transfer of care. If you are requesting copies of your medical records for yourself, a copy fee, postage, and sales tax will be charged to your account.

Link Community Clinic Credit Card on File Agreement

We have implemented a payment policy using a credit card on file, to streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their copayments, deductibles, & bills.

ALL PATIENTS, new and existing will be asked for a credit card at the time of your first appointment, and this information will be held securely. The amount that we will charge to the credit card on file will be the financial responsibility that the insurance company requires you to pay. Credit card information will be protected and stored via our HIPAA compliant, processing card portal.

Cards on file will be used for deductibles, copayments, and any outstanding balances that have been discussed with the patient. Any deductible or copayment amount that is patient responsibility will be processed **at the time of service**.

Claim Filing: We happily file your claim with your insurance company as a courtesy. Please keep in mind that payment remains your responsibility. We do not enter disputes over insurance benefits. We bill insurance in accordance with all federal, state and other contractual requirements in cases where we have an agreement, or we are a participating provider. We expect payment in full of you if your insurance company delays processing of your claim for over 60 days. You agree to pay any portion of the charges not covered by insurance.

Waiver of Requirement: IF your primary insurance is a state plan you are eligible to waive completing this form. If your insurance changes at any point where it is no longer a state plan and has become a commercial plan, you will no longer be eligible for the waiver and will have to comply with policy in keeping a card on file.

Select this box if your primary insurance is a state plan and you wish not to provide a card on file: ☐

OPT OUT OPTION: TELEHEALTH RESTRICTED: IF a patient does not feel comfortable having a card on file and does not want to comply with the policy change, their account will be flagged as not ineligible for telehealth visits and they will not be allowed to be scheduled. If a telehealth visit does get scheduled, a request for a card on file will be made, if not successful in obtaining one before the appointment, the visit will get canceled.

Please check here if you choose to opt out of having a card on file and having telehealth visits: ☐

By signing below, I agree to all of Link Community Clinic Credit Card on File Policy, and I authorize Link Community Clinic to keep my signature and a valid credit/debit card number securely on-file in my account. I allow Link Community Clinic to automatically charge my credit card at the time of my appointment for deductibles, copayments, & balances if applicable.

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give Link Community Clinic a new, valid credit card which I will allow them to key-in over the phone. Even though Link Community Clinic is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card which I presented in person.

I understand that I am responsible for payment for all services provided to me by Link Community Clinic. I understand that this form is valid until I cancel this authorization through written notice to Link Community Clinic.

By signing this form, patient and/or guardian if patient is a minor, agrees and consents to all the above terms and policies.

Today's Date*	Patient Full name*	Patient

Link Community Clinic Credit Card on File Agreement

Link Community Clinic

107 N. Tacoma Ave.
Tacoma, WA 98403
P 253 267 1317
F 253 212 3128

Credit Card on File Agreement

We have implemented a new policy, which enables you to maintain your credit card information on file in our office. This information will be securely held until your insurance provider has paid their portion of your bill and notified us of the amount that is your responsibility. At that time, any balance, which you owe to our office for medical services that have been performed, will be charged to your credit card.
Co-pays are due at time of service and will automatically be charged the morning of a telehealth appointment.
I authorize LINK COMMUNITY CLINIC to charge any outstanding balances on my account, including co-pays, coinsurance, late cancellation and no show fees to the following card.

Visa Mastercard

Name on Card: _____

Billing Address: _____

_____

Card number: _____

3 Digit Security code: _____ Expiration: _____ Billing Zip Code: _____

Signature: _____

Today's Date: _____