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 PEDIATRIC PATIENT HEALTH QUESTIONNAIRE

Please use the back of this page if you need more space for your responses

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

Name of person filling out the form: _____ **Relationship to patient:** _____

Gender *Please circle* female ☐ male ☐ not listed _____

Sex assigned at birth *Please circle* female ☐ male ☐ intersex ☐ not listed _____

Your answers to the following questions will help us understand your or your child's medical history. Please fill out as much information as possible. If you cannot answer a question or feel uncomfortable answering a question, please leave them blank. Thank you for your help.

Household Members *Please list all household members that live with the patient. Overflow space on back of page.*

Name	Relationship to child	Birth date	Health Problems

☐ Adopted ☐ Foster care ☐ Parents divorced/separated ☐ Joint custody parents (incl. married) ☐ Single custody parent

Birth History

Birth weight _____lbs _____ oz	☐ Full term birth	☐ Premature ____ wks	☐ Vaginal birth	☐ C-section
Hospital name_____		Hospital City, State_____		
☐ Pre-/neo-natal complications? Explain: _____			☐ NICU Stay - How long? _____ weeks	
☐ Tobacco use during pregnancy	☐ Alcohol use during pregnancy		☐ Medication/drug use during pregnancy	

Medical History *Please check or list any medical problems your child has experienced.*

☐ Problems with hearing or ears	☐ Problems with vision or eyes	☐ Allergies
☐ Asthma or wheezing	☐ Heart murmur or heart disorder	☐ Depression/Anxiety/ADHD/Mood disorder
☐ Headaches/migraines	☐ Kidney disease or recurring UTIs	☐ History of head injury or concussion
☐ Seizures	☐ Substance use or abuse	☐ Snoring/Obstructive sleep apnea
☐ Surgeries - Type of surgery/year? _____		☐ Other _____

Family Medical History *Please check or list any medical problems in your child's biological family.*

☐ Asthma	*Who?*	☐ Early sudden death	*Who?*
☐ Cancer	*Who?/Type?*	☐ High cholesterol	*Who?*
☐ Depression/Anxiety/Mental Illness	*Who?*	☐ Diabetes	*Who?*
☐ Stroke/Cardiovasc. dz/Heart attack < age 55y	*Who?*	☐ Substance abuse	*Who?*
☐ High blood pressure	*Who?*	☐ Childhood hearing loss	*Who?*
☐ Other	*What/Who?*		

Physical Activity How many days does your child engage in strenuous physical activity (walking/running/swimming/dancing/etc)?

days in a week: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

On average, how many minutes does your child engage in exercise at this level each time?

☐ 0 ☐ 10 ☐ 20 ☐ 30 ☐ 40 ☐ 50 ☐ 60 ☐ 70 ☐ 80 ☐ 90 ☐ >90

Medications/Supplements *Please list all names and doses of medications/supplements/vitamins and conditions for which they are taken.*

Medication or supplement	Dose and how often	Condition

Medication Allergies *Please list the name of the medication and the reaction your child experienced.*

Medication	Reaction

Other Healthcare Providers *Please list your child's previous doctor and any specialists (e.g, allergist, counselors, etc.) that care for your child.*

Doctor's/Care Provider's Name	Type of physician/specialty and Location

Thank you for your time. Your child's medical history is very important to us!

Household Members *Overflow*

Name	Relationship to child	Birth date	Health Problems

Medications/Supplements *Overflow*

Medication or supplement	Dose and how often	Condition

Medication Allergies *Overflow*

Medication	Reaction

Other Healthcare Providers *Overflow*

Doctor's/Care Provider's Name	Type of physician/specialty and Location

Any addition al comments/information you would like to include:

Pediatric Review of Systems

Newborn to 18 years of Age

Name: _____ DOB: _____ Date: _____

GENERAL

- ☐ Fever
- ☐ Chills
- ☐ Weakness
- ☐ Fussiness
- ☐ Poor feeding/change in appetite
- ☐ Sleep disturbance
- ☐ Sleeping more than usual
- ☐ N/A

BREASTS:

- ☐ Breast pain
- ☐ Breast lumps or Mass
- ☐ Nipple changes
- ☐ Nipple discharge
- ☐ N/A

NEUROLOGICAL

- ☐ Headaches
- ☐ Dizziness
- ☐ Incoordination
- ☐ Seizures
- ☐ Speech delay
- ☐ Recent head injury
- ☐ N/A

RESPIRATORY

- ☐ Cough
- ☐ Phlegm production
- ☐ Working hard to breathe
- ☐ Noisy breathing
- ☐ Wheezing
- ☐ N/A

EYES

- ☐ Eye drainage
- ☐ Eye pain
- ☐ Eye redness/swelling
- ☐ Itchy eyes
- ☐ Light sensitivity
- ☐ N/A

CARDIOVASCULAR:

- ☐ Fast/irregular heartbeat
- ☐ Fainting
- ☐ N/A

MUSCULOSKELETAL

- ☐ Swelling
- ☐ Refuse to use extremity
- ☐ Pain site_____

ENDOCRINE

- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urination
- ☐ Weight changes
- ☐ N/A

GI/ABDOMINAL

- ☐ Abdominal pain
- ☐ Abnormal stools
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Black or bloody stools
- ☐ N/A

ENT

- ☐ Ear pain
- ☐ Ear drainage
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Runny nose
- ☐ Sore throat
- ☐ Excessive drooling
- ☐ N/A

SKIN

- ☐ Bruising
- ☐ Itching
- ☐ Changes in moles
- ☐ Rash
- ☐ Wounds
- ☐ N/A

PSYCHOLOGICAL

- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal
- ☐ Irritability
- ☐ Attention problems
- ☐ Sleep problems
- ☐ N/A

GENITOURINARY:

- ☐ Painful urination
- ☐ Frequency
- ☐ Blood in urine
- ☐ Pants/bed wetting
- ☐ Foul-smelling Urine
- ☐ N/A

GU-MALES ONLY

- ☐ Penile discharge
- ☐ Testicular swelling
- ☐ Testicular pain
- ☐ N/A

GU-FEMALES ONLY

- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Abnormal menstrual periods
- ☐ N/A

IMMUNE

- ☐ Allergic reaction
- ☐ Eczema
- ☐ Hives
- ☐ Seasonal allergies
- ☐ N/A

OTHER SYMPTOMS:

_____

_____

_____

_____.

link
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.

link
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 North 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: _____