DANIEL M. KATZ, D.O.
Osteopathic Physician and Surgeon

Date:________________________

Name: (First) ________________________ (M.I.)__________ (Last)________________________
If under 18, Guardian name:____________________ Relationship:______________________
Address:____
Date of Birth:________________________ Sex: Male ☐ Female ☐
Home Phone:________________________ Cell Phone:________________________
Employer:________________________ Work Phone:________________________
Occupation:________________________ Employer's Address:________________________
Driver's License #____________________ May we call you at work, if needed? (circle) Y or N
Social Security Number (if pt. is a minor, please list parent's)______________________
Marital Status: (please circle) Single/Married/ Widowed
Email Address:____
Would you like your appointment reminders made through phone or email? ______________
How did you learn of our practice?____

Insurance Information:
Primary Insurance Company:________________________ Effective Date:______________
Subscriber Name:________________________ Subscriber DOB:______________
Policy #________________________ Group#:______________
Secondary Insurance Company:________________________ Effective Date:______________
Subscriber Name:________________________ Subscriber DOB:______________
Policy #________________________ Group#:______________

Assignment of Insurance Benefits:

The undersigned herby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and /or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, ______________________________, hereby authorize ______________________________
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Daniel M. Katz, D.O., all benefits, if any, otherwise payable to me for his services. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Daniel M. Katz, D.O. will be creditted to my account, in accordance with the above said assignment. I have been provided, and have read the Payment Policies for Dr. Daniel Katz.

______________________________ ______________________________
Authorized Signature or Subscriber Today's Date

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations).

____

Please list the family members, or significant others, if any whom we may contact/inform about your medical condition ONLY IN AN EMERGENCY:

Phone #
____
Phone #
____

Please indicate if you prefer ALL correspondence from our office be marked "**CONFIDENTIAL**" YES ☐ NO ☐
Can confidential messages (test results, appointment reminders be left on your voicemail? YES ☐ NO ☐

Patient/Guardian Signature______________________________ Date ______________

405 Black Hills Lane SW, Suite B1 Olympia, WA 98502 Ph: 360-705-1015

DANIEL M. KATZ D.O
OSTEOPATHIC PHYSICIAN & SURGEON

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee is to ensure that your health information is never compromised. Should we ever need to make any changes to our privacy policies, we will provide you an updated copy at your next appointment.

Protecting Your Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act (HIPAA) and the State of Washington. Your personal information will never be given to anyone, including family members, without your written consent. You are able to update the specific permission/restriction rights at any time, via written request.

Collecting Protected Health Information

We will only request personal information needed to provide our standard quality of medical care, conduct payment activities and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. Most of this information will be collected from you, however some information could be obtained from a third party when deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Use & Disclosure of Your Protected Health Information

The following categories describe different ways that we use and disclose medical information: For treatment; For payment; For treatment alternatives; For health-related benefits and services; For individuals involved with your care and/ or payment; As required by law; To avert a serious threat to health or safety. As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use or disclose your health information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards. We may also send non-health related communications to you for the following purposes: newsletters, birthday cards, surveys, updates to policy and other matters as they arise.

Patient Rights

You have the right to request copies of your healthcare information. All requests must be in writing. We may charge for your copies in an amount that is allowed by law. You have the right to request restrictions on the uses and disclosures of your Health Information. We are not required to comply with your request. You have the right to request that we amend your Health Information made by us that is incomplete or incorrect. We are not required

to change your information, and will provide you with information about our denial, and how you can disagree with our denial.

If you believe your rights have been violated, we urge you to notify our Office Manager, Mandy Failor, at 360-705-1015, or The Department of Health & Human Services.

We appreciate your being a part of our practice and allowing us to care for you and your family.

DANIEL M. KATZ, D.O.
Osteopathic Physician and Surgeon

Payment Policy and Privacy Policy Acknowledgement

We accept CHECK, CASH, VISA OR MASTER CARD.

Payment for services you receive are to be paid in full at the time services are rendered unless other arrangements have been made. If a blance is generated, a 1.0% service fee will be charged after 30 days.

INSURANCE:

*We will accept and bill most insurance plans. Extent of coverage may vary with these plans. Please contact your insurance, union, or employer regarding the extent/limiations of coverage.

*Assignment of Benefits to Daniel M. Katz, D.O. must be signed.

*We require that your deductible and/or co-payment be paid in full at the time services are rendered.

*State law requires insurance companies to process any single claim within sixty (60) days. If payment has not been received in 60 days, you will be responsible for the full amount.

*You are responsible for handling any delays or disputes involving your insurance company. Our office will provide assistance, when applicable.

*Our fees for services are the same whether or not you have insurance coverage.

*A charge will be made for appointments cancelled or broken without 24 hours advance notice.

*Should the account be referred for collection the undersigned shall pay reasonable attorney fees and collection expenses. All delinquent accounts bear interest at the legal rate. In the event of court action, venue and jurisdiction shall be Thurston County in the State of Washington.

I HAVE READ THE ABOVE POLICY AGREEMENT AND UNDERSTAND MY RESPONSIBILITIES FOR PAYMENT OF SERVICES.

Patient/Guardian Signature ________________ Date ________________

I HAVE READ AND RECEIVED A COPY OF THE *PRIVACY PACTICES OF DANIEL M. KATZ, D.O.*

Patient/Guardian Signature ________________ Date ________________

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DANIEL M. KATZ D.O.
OSTEOPATHIC PHYSICIAN & SURGEON

Personal Health:

Have you had any of the following?

Alcohol, or other drug problem: Yes ☐ No ☐ ____________________

Anxiety/Mood Disorder: Yes ☐ No ☐ ____________________

Depression: Yes ☐ No ☐ ____________________

Arthritis: Yes ☐ No ☐ ____________________

Asthma : Yes ☐ No ☐ ____________________

Emphysema: Yes ☐ No ☐ ____________________

Digestive Problems (i.e. acid reflux, bowel problems, etc.)
Yes ☐ No ☐ ____________________

Kidney or Bladder problems: Yes ☐ No ☐ ____________________

Headaches: Yes ☐ No ☐ ____________________

Neurologic Disorders (i.e. MS, seizures, etc.)
Yes ☐ No ☐ ____________________

Heart Disease: Yes ☐ No ☐ ____________________

High Blood Pressure: Yes ☐ No ☐ ____________________

High Cholesterol: Yes ☐ No ☐ ____________________

Thyroid Condition: Yes ☐ No ☐ ____________________

Cancer: Yes ☐ No ☐ ____________________

If answering yes to cancer, what type? ____________________

Other significant medical condition(s): ____________________

Please list any previous surgeries with approximate year: ____________________
____
____

Has there been any previous long-term use of pain medication (Vicodin, Hydrocodone, Oxycodone, etc)?
Yes ☐ No ☐

Patient Last Name: ______________ First Name: ______________ DOB: __________

Family Health:

Is your mother still living? Yes☐ No ☐ Age now, or at death:_________

Is your father still living? Yes☐ No ☐ Age now, or at death:_________

Illnesses in your family :

Mother:____

Father:____

Brothers/Sisters:____

Has any immediate family member (mom, dad, brother, sister) had any of the following conditions? If yes, who and at what age was diagnosis?

Breast Cancer: Y/N _________________ Colon Cancer: Y/N _____________________
Diabetes: Y/N __________________ Heart Attack: Y/N _____________________

Other significant family history: ____

Are you allergic to any drugs or medications? If yes, please list:_____________________________
____

Current Smoker? Y/N If yes, how much?___________ How long?__________
Past Smoking History? Y/N If yes, how much? ___________ How long?_________
Do you use alcohol? Y/N If yes, how much/often? ________________________

Please list all current medications:

Current Medications: *If additional space is needed for list, please detail on side of page

Drug:	Dosage:	For what condition:
	- -	
	- -	
	- -	
	- -	
	- -	

For Women Only:
Number of children, and ages? ______________________________
Have you reached menopause? Yes ☐ No☐
Are you currently under the care of a gynecologist? Yes ☐ No ☐

Patient Last Name: ____________________ First Name:____________________ DOB:___________

DANIEL M. KATZ, D.O
OSTEOPATHIC PHYSICIAN & SURGEON

405 Black Hills Lane SW, Suite B 1
Olympia, WA 98502
(360) 705-1015 - phone
(360) 705-1313 - fax
office@drdanielkatz.com - email

mailing: PO Box 11667
Olympia, WA 98508

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:______________________________ Date of Birth: ________________________

Previous Name: ______________________________ Last 4 of SSN: ________________________

I request and authorize ____ to
release healthcare information of the patient named above to:

DANIEL M. KATZ, D.O.
P.O. BOX 11667
OLYMPIA, WA 98508-1667

The request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition or dates:____________________
____

☐ All healthcare information

☐ Other:____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid lymphogranuloma, venereuem, HIV, AIDS and gonorrhea.

☐ Y ☐ N I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
☐ Y ☐ N I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

Patient Signature:____ Date:____________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER ITS SIGNED