DANIEL M KATZ D.O.
Osteopathic Physician and Surgeon

Patient Registration Form

Today's Date: _____

Patient Information

First Name	Middle Name	Last Name	
Sex / Martial Status		Date of Birth	Social Security Number
Patient's Mailing Address		City	State / Zip Code
Home Phone	Cell Phone	Work Phone	ok to call at work?
Please indicate if it is okay for us to leave a confidential voice mail that may include test results, prescription information, or any other medical information pertaining to your health. This should be a phone number that only you, or anyone that you are comfortable with hearing our medical information, has access to. ___Yes ___No			
Phone number that it is ok to leave message on		Initials:	
Occupation	Employer		
Preferred Pharmacy		Pharmacy City	
How May we Contact You? Please Select All That Apply Email ☐ Home Phone ☐ Cell Phone ☐			
Email Address		How did you hear about our practice?	

Parent/Guardian (if patient is under 18)

First Name	Middle Name	Last Name	
Mailing Address	City	State	Zip Code
Home Phone	Cell Phone	Work Phone	ok to call at work?

Primary Medical Insurance

Medical Insurance ☐ Worker's Comp ☐ Auto Insurance ☐			
Insurance Company Name	ID #	Group #	
Name of Subscriber(Must have name, SSN DOB To bill	Subscriber's Social Security	Subscriber's Date of Birth	
Worker's Comp and Auto Insurance Only			
Date of Accident	Claim Adjuster Name	Phone number	Claim Number
Secondary Medical Insurance			
Secondary Insurance Name	ID #	Group #	
Name of Policy Holder	Social Security #	Date of Birth	

Emergency Contact Information

Name	Relationship	Phone Number

Name of person who can have access to your general medical condition and your diagnosis (including treatment, payment and health care operations)

Name	Relationship	Phone Number

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

DANIEL M KATZ D.O.
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Agreement to Pay for Treatment

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or third party insurer or other payor. I further understand that if I do not show for an appointment or give 24 hour notice to Daniel M Katz D.O. PLLC, I may be responsible for the charges up the potential cost of the visit.

X _____

Responsible Party Signature **Date**

Release and Statement to Permit of Private Insurance Benefits to the Provider

I, hereby authorize Daniel M Katz, D.O. PLLC, and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, or all or part of the provider charges.
I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.
I, authorize, the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.
I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.
I, authorize and request that payment of any third party or insurance company benefits be made directly to Daniel M Katz, D.O., PLLC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X _____

Responsible Party Signature **Date**

Consent for Treatment

By signing below, I, undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including labs, as ordered by this office and it's healthcare providers.

X _____

Responsible Party Signature **Date**

I have read and received a copy of the privacy practices of Daniel M Katz D.O.

X _____

Responsible Party Signature **Date**

**** Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.***
**** Some Contract Health Plans (HMO, PPO, etc.) require a co-payment at the time of service. Please have this ready prior to your visit as well as any current balance due. If there is a past due balance at time of visit, patient may be required to reschedule the appointment.***
**** If a balance is generated, a 1.0% service fee will be charged after 30 days.***
**** You are responsible for handling delays or disputes involving your insurance company. Our office will provide assistance, when applicable.***
****Our fees for service are the same whether or not you have insurance.***
**** 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 juridiscation shall be Thurston County in the State of Washington.***
****My visit my also be forfited if I have not done my labs or confrimed my appointment with office staff 48 hours prior to my visit.***

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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:_____

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

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:_____

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 immediate 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?_____

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:_____

Medical Records Release/Request Form

Patient Authorization for Use or Disclosure of Protected Health Information

As required by the Health and Accountability Act of 1996 (HIPAA), a practice may not use or disclose your identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you give permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete those sections detailing the information to be released, and the purposes for the disclosure.

I hereby authorize, (previous Dr) _____ to release health information on the patient named below:

Name (print)_____ **Date of Birth** _____

Other Name i.e.; (maiden)_____ **Telephone** _____

Address _____ **City/State** _____ **Zip** _____

I Authorize the Release Of:

☐☐**ALL** my health information maintained ☐☐Include Previous Provider Records

☐☐My health information relating to the following treatment or condition: _____

☐☐My health information for the date(s):_____ ☐☐Other: _____

Reason For Release (must be noted): _____

Send/Release Medical Records To: Daniel M Katz DO **Address** PO Box 11667

City Olympia **State** WA **Zip** 98508 **Phone** 360-705-1015 **Fax** 360-705-1313

RESTRICTIONS: I understand that the recipient of this information may not use or disclose this information except for the expressed purposes identified above, unless another authorization is obtained from me, or such use or disclosure is specifically required or permitted by law.

I understand that my medical record may include information relating to sexually transmitted disease; acquired immunodeficiency syndrome (AIDS); human immunodeficiency virus (HIV); behavioral/mental health services; and/or treatment for alcohol and/or drug abuse.

PLEASE Check ALL Requested Exclusions: ☐☐Alcohol/Drug ☐☐Behavior/Mental Health/Psychiatric ☐☐Sexually, Transmitted Disease

☐☐HIV/AIDS ☐☐Other; specify exclusion_____

I understand that I have the right to request that a service for which I have paid out-of-pocket, not be disclosed to my health plan.

This Authorization is Effective: Date_____ through_____(dates must be specified)

SIGNATURE: _____ PRINT NAME: _____ DATE: _____

Patient /Guardian/Parent/Patient's Representative

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REFUSAL TO SIGN AUTHORIZATION: I understand that by declining to sign this form my medical (health care) treatment and insurance benefits will not be affected, however, my medical records **CANNOT** be released. I understand that I may revoke this authorization at any time by notifying the X in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken the X prior to its receipt. I understand that, if the recipient of the information is not a health care provider or health plan covered by HIPAA, the information used or disclosed as described above may be re---disclosed by the recipient and no longer protected by HIPAA. However, other state or Federal laws may prohibit the recipient from disclosing specially protected information, such as abuse treatment information, HIV/AIDS---related information, and psychiatric/mental health information.

Daniel M Katz D.O.

Authorization Form
PO Box 11667 Olympia, WA 98501
360-705-1015 Fax 360-705-1313

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following person (or class of persons) may receive disclosure of protected health information about me:

Name and Relation to Patient

Address

City, State Zip Code

2. The specific information that should be disclosed is (please give dates of service if possible):

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, DO NOT DISCLOSE THIS INFORMATION * _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying **Daniel M Katz DO**, in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for _____.
6. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signature.

Official Use Only

Received	**Processed By**	**Log #**

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 (HIPPA) 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 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/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 our 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, Angie Valderrama, at 360-705-1015, or The Department of Health & Human Services.

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