Proliance®
Eastside Surgical Specialists

Patient Registration

Patient Name: _____ Social Security #: _____

DOB: _____ Sex M ☐ F ☐ Marital Status: _____

Billing Address: _____

Primary Phone#: _____ Home Phone#: _____

Alternate Phone#: _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Insurance Information

Primary Insurance Name: _____ ID#: _____

Name of Insured/Subscriber: _____ Group #: _____

Date of Birth of Insured/Subscriber: _____ Relationship to Patient: _____

Employer Name: _____ Phone#: _____

Secondary Insurance Name: _____ ID#: _____

Name of Insured/Subscriber: _____ Group #: _____

Date of Birth of Insured/Subscriber: _____ Relationship to Patient: _____

Employer Name: _____ Phone#: _____

Is this a work-related injury? Check Y ☐ N ☐

Worker's Comp. Claim#: _____ *Date of Injury: _____

Case Manager's Name: _____ *Phone#: _____

Emergency Contact Information

Name _____ Relationship _____ Phone#_____

Name _____ Relationship _____ Phone#_____

Signature **Date**

_____ _____

Relationship to patient (other than Self): _____

1231 116th Ave NE, Suite 535 Bellevue, WA 98004
T 425-688-1916 F 425-688-1901

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Patient Financial Responsibilities

Proliance Eastside Surgical Specialists, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Proliance Eastside Surgical Specialists.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

• Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
• Knowing your insurance benefits and limitations
• Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
• Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
• Paying your estimated portion of the charges at the time of service
• Paying any additional amount owed when due
• Completing required incident/accident forms within 30 days of date of service
• Maintaining a current account with Proliance Surgeons at all times
• Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment
Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $250.00 deposit is required. If visits and services are paid in full, we offer a 20% discount (see exclusions below). Charges are not finalized until chart notes are complete.

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid in full prior to the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of cosmetic procedures, motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.
Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients -
We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation
If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $250.00 deposit that will be refunded after the claim has been opened.

Other Charges
No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.
Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept checks, major credit/debit cards, and money orders for payment (no post-dated or third-party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We may assign an account to collections if balances are unpaid after 90 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Proliance Eastside Surgical Specialists or any other Proliance Surgeons care centers may be required to pay for their portion of new charges at the time of service.

Signature of Patient/Parent/Power of Attorney	**Printed Name of Patient**	**Date**

I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release information required for my medical claim. I consent to the release of medical information from or to other doctors and healthcare insitutions as is necessary to my care and treatment. This authorization is valid for 12 months from the date it is signed.

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Eastside Surgical Specialists

Helen Kim, MD, FACS
Mitra Ehsan, MD, FACS, FASCRS

Authorization to Leave Personal Health Information, Alternate Means

Patient Name: _____ DOB: _____

Mailing Address: _____

Please fill in all that apply.

1. May leave detailed message on voicemail at Primary Number: _____

2. May leave detailed message on voicemail at Alternate Number: _____

3. May leave information with spouse (name): _____

4. May leave information with other family member (name):_____

5. May leave information at different location (specify):_____

_____ _____

Signature of Patient/Parent/Power of Attorney **Date**

Note: With my signature, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my health care provider(s) should I change one or more of the contacts listed above.

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Helen Kim, MD, FACS
Mitra Ehsan, MD, FACS, FASCRS

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and obtain a copy of that record. You may also ask to correct said record. We will not disclose your 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 manager of the location at which you have been treated. Please call the main office number and ask for the clinic manager.

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. You may obtain a copy of our Notice of Privacy Practices at any point by requesting one from the staff.

_____ _____

Signature of Patient/Parent/Power of Attorney **Date**

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PATIENT HEALTH HISTORY FORM

HT _____ WT _____

PLEASE LIST CURRENT MEDICATIONS Mgs/Strength/Dosage

_____

_____

_____

_____

_____

_____

ARE YOU CURRENTLY TAKING ASPIRIN? Y ☐ N ☐ DOSAGE_____

ARE YOU CURRENTLY TAKING ANY OTHER BLOOD THINNERS? Y ☐ N ☐

DOSAGE_____ NAME OF MEDICATION_____

PLEASE LIST CURRENT ALLERGIES

_____

_____

_____

_____

PAST SURGICAL HISTORY **YEAR/OPERATION**

_____

_____

_____

_____

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PATIENT HEALTH HISTORY

Have you ever been seen by a cardiologist? : Y ☐ N ☐ Name/Location of Cardiologist: _____

Have you or any relatives had any problems with anesthesia? : Y ☐ N ☐ Please Describe: _____

_____

When and where was your most recent EKG? _____

Can you climb 2 flights of stairs without shortness of breath? Y ☐ N ☐ Do you require assistance? Y ☐ N ☐

PERSONAL HEALTH HISTORY

HIGH BLOOD PRESSURE : Y ☐ N ☐
GLASSES/DENTURE : Y ☐ N ☐
ARTHRITIS/GOUT : Y ☐ N ☐
DIABETIC : Y ☐ N ☐ TYPE I ☐ or II ☐
MRSA : Y ☐ N ☐ ACTIVE MRSA: Y ☐ N ☐
PULMONARY EMBOLISM : Y ☐ N ☐
CORONARY ARTERY DISEASE : Y ☐ N ☐
HIGH CHOLESTEROL : Y ☐ N ☐
CPAP MACHINE : Y ☐ N ☐

PACEMAKER : Y ☐ N ☐ (IF YOU ANSWERED YES PLEASE LIST BRAND/MODEL #_____)

SOCIAL HISTORY AND HEALTH HABITS

Relationship Status	Single ☐	Partnered ☐	Married ☐	Separated ☐	Divorced ☐	Widowed ☐
Smoking	Y ☐ N ☐	Type:		Packs per day :		Quit (Year) :
Alcohol	Y ☐ N ☐	Drinks per week :				Quit (Year) :
Drugs(Not Prescription)	Type :					
Marijuana use?	Y ☐ N ☐	Amount:		Route:		

Please list any major health issues for the following family members, if deceased; please give cause of death

Mother		Father	
Grandfather		Grandfather	
Grandmother		Grandmother	
Aunt/Uncle		Aunt/Uncle	
Siblings and or other Relatives (Please list)			

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☐ **None Applies**

Constitutional Symptoms
- ☐ Weight Loss / Gain: _____lbs
- ☐ Fevers
- ☐ Night Sweats

Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration

Head and Neck
- ☐ Sinus Infection
- ☐ Swollen Glands
- ☐ Dentures/Partial Plate
- ☐ Radiation to Face or Neck

Heart
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Shortness of Breath Standing/Laying Down
- ☐ Swelling in Feet or Legs
- ☐ Heart Stents
- ☐ **Pacemaker**

Lungs
- ☐ Asthma/Wheezing
- ☐ COPD/Emphysema
- ☐ Respiratory Infections
- ☐ **Sleep Apnea**

Gastrointestinal
- ☐ Heartburn/GERD
- ☐ Ulcers
- ☐ Frequent Diarrhea
- ☐ Constipation
- ☐ Blood in Stool
- ☐ Hemorrhoids
- ☐ Hepatitis

Genitourinary
- ☐ Difficulty Voiding
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Painful Urination

Fertility/Reproduction:
- ☐ Pregnancies : _____
- ☐ Miscarriages : _____
- ☐ Delievery Type : _____
- ☐ Menopause/Post-Menopausal
- ☐ Tubal Ligation
- ☐ Vasectomy

Muscles/Joints :
- ☐ Arthritis
- ☐ Joint Replacement
- ☐ Back Pain

Skin:
- ☐ Rashes
- ☐ Skin Cancer
- ☐ MRSA (ACTIVE)
- ☐ History of MRSA

Breasts:
- ☐ Breast Pain R L Bilateral
- ☐ Breast Mass R L Bilateral
- ☐ Nipple Discharge R L Bilateral

Neurologic:
- ☐ Loss of Memory
- ☐ Seizures
- ☐ Migraines
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Stroke

Endocrine:
- ☐ Thyroid Problems
- ☐ Diabetes (Type I / Type II)

Blood Problems:
- ☐ Anemia/Bleeding Problems
- ☐ Clotting Problems
- ☐ Transfusions History

Allergies:
- ☐ Seasonal Allery
- ☐ **Latex**
- ☐ Iodine/Contrast