

I understand that I have the right to a fair, fast and objective review of any complaint I have against Seattle Premier Health, including complaints about wait times, operating hours, conduct of personnel, business practices and adequacy of health-care services and facilities.

In order to receive the best possible care, I agree to be actively involved in my health-care decisions and to disclose all relevant information to my Seattle Premier Health physicians so that they can help me achieve my health goals. I also agree to inform my Seattle Premier Health physicians of any health-care services I receive outside of Seattle Premier Health, such as specialist, hospital or emergency room services, so that my physicians can better serve my needs.

### Patient Signature

By my signature below, I agree to become a Seattle Premier Health patient and I agree to the terms outlined in this Patient Agreement.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

## Patient Profile

To make the most of your Premier Health visit, please take the time to fill out this form as completely as possible. Your answers will help our physicians and staff prepare for your visit.

### Patient Information

Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

Home address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

E-mail address \_\_\_\_\_

Alternate address \_\_\_\_\_

Preferred method of contact \_\_\_\_\_

May we provide personal information in a voice mail?

Yes No

May we provide personal information in an e-mail?

Yes No

What sex were you assigned at birth on your original birth certificate?

Male Female Choose not to disclose

Current Gender Identity \_\_\_\_\_

Currently: Married Partnered Widowed Single

Present marriage/domestic partnership (years) \_\_\_\_\_

Current employer

\_\_\_\_\_ Position

\_\_\_\_\_

### Legal Next of Kin

Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

Phone \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to patient \_\_\_\_\_

(spouse, parent, adult child, sibling, other)

### Alternate Contact

Name (Last) \_\_\_\_\_

(First) \_\_\_\_\_ (MI) \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

Are you most likely to be at your alternate address during a specific time of year? \_\_\_\_\_

### Insurance Information

Carrier: \_\_\_\_\_

Cardholder \_\_\_\_\_

Subscriber ID# \_\_\_\_\_

Group ID# \_\_\_\_\_

Your relationship to cardholder \_\_\_\_\_

Note: Although Seattle Premier Health will not bill your insurance company for any goods or services we provide in our office, we may use your insurance information to facilitate referrals to outside service providers, including specialists, diagnostic tests or lab services, who may bill your insurance company.

## Preferred Physician

Do you have a preference for your primary physician?

Dr. Karen James                      Dr. Chris Leininger  
Dr. Mark Lacambra                  Dr. Michelle Seelig

If you would like to meet with one or both of the physicians before choosing, please call our office at 206-215-4300 to set up an interview appointment at no charge.

If your preferred physician has no space available, would you like to be assigned to the other physician, or would you rather be placed on a waiting list?

Assigned to other physician                  Placed on waiting list

## Payment Information

Please provide your credit/debit card information:

Card type:    Visa            MasterCard            American Express

Card number \_\_\_\_\_

Name on card \_\_\_\_\_

Expires \_\_\_\_\_

Security code \_\_\_\_\_

(3 digits on back of card; 4 on front upper right of American Express)

Cardholder's billing address:

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_                      ZIP \_\_\_\_\_

## Authorization For Recurring Credit/Debit Card Transactions

I authorize Seattle Premier Health to charge my credit/debit card for my Seattle Premier Health fee and the fees for any family members included on my account. When my financial institution honors the transaction, this shall constitute my receipt for payment.

I understand that the transaction amount is the total of my fee plus the fees of any family members included on my account.

I understand that my participation in Seattle Premier Health is continuous and that recurring credit/debit card charges are authorized and will continue until I provide Seattle Premier Health with written notice to discontinue such transactions.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## Patient Agreement

### Terms

I acknowledge and understand that I am voluntarily becoming a Seattle Premier Health patient and that this agreement is non-transferable.

I have reviewed the Seattle Premier Health Guide to Patient Services, which describes the services provided, those not provided and the general policies of Seattle Premier Health. I have been able to ask questions and receive answers regarding its content.

I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage, nor is it an insurance contract. This agreement provides only the health-care services specifically described in the Seattle Premier Health Guide to Patient Services.

I acknowledge and understand that I am responsible for any charges incurred for health-care services performed outside of Seattle Premier Health, including but not limited to specialty care, hospital and emergency room services, diagnostic imaging and lab tests. Seattle Premier Health recommends that its patients have health insurance for services not provided by Seattle Premier Health. Seattle Premier Health will not bill my insurance company for any services provided.

I acknowledge and understand that Seattle Premier Health will use and disclose my health information only as stated in the Notice of Privacy Practices. I understand and acknowledge that this policy has been provided to me.

I acknowledge and understand that I am free to terminate this Patient Agreement at any time, for any reason or for no reason by providing written notice to Seattle Premier Health.

I acknowledge and understand that Seattle Premier Health may terminate this Patient Agreement by giving me written notice. Seattle Premier Health will close my billing account the month following the termination of my contract.

I acknowledge and understand that if I am enrolled in Medicare, I will receive a copy of the Contract with Medicare Beneficiaries for review and signature before my first appointment. (The contract does not prevent me from receiving my current or future Medicare benefits from non-Seattle Premier Health providers — it only states that neither I nor Seattle Premier Health will seek reimbursement from Medicare for the medical services I receive from Seattle Premier Health.)

### Rights and Responsibilities

I understand that I have the right to choose my Seattle Premier Health physician and to request to change physicians at any time, for any reason. I understand that Seattle Premier Health will make all reasonable efforts to accommodate my request, but if the physician I request does not have availability, the request may not be possible.

I understand that I have the right to receive accurate and easily understood information about the services, facilities and health-care professionals of Seattle Premier Health.

I understand that I have the right to know my treatment options and to participate in decisions about my care.

If I cannot make my own decisions, parents, guardians, family members or other individuals whom I designate can represent me.

I understand that I have the right to considerate, respectful and nondiscriminatory care from my Seattle Premier Health care providers. I also understand that in turn, I am responsible for communicating clearly and respectfully my wants and needs regarding my health care and the services I receive. If I become dissatisfied with my care or the services provided, I agree to notify Seattle Premier Health immediately so my concerns can be addressed in a timely manner.

I understand that I have the right to talk in confidence with my Seattle Premier Health physicians and to have my health-care information protected in accordance with the Notice of Privacy Practices. I also understand that I have the right to receive a copy of and review my medical record and may request that it be amended if I feel it is not accurate or complete.