SMA Use Only - Date Received: ____________________

Sequim Medical Associates, PLLP

840 N 5th Avenue, STE#2100 Sequim, WA 98382 Office (360) 582-2850 Fax (360)582-2851

DATE ______________________ **DOCTOR** ______________________________

LEGAL NAME ____ **NICKNAME** ______________
Last First Middle

BIRTHDATE ______________________ **AGE** ________ **GENDER:** **M** **F**

PHYSICAL ADDRESS: ____

CITY ______________________ **STATE** ______________ **ZIP** ____________

MAILING ADDRESS (if different): ____________________________________

CITY ______________________ **STATE** ______________ **ZIP** ____________

HOME PHONE ____________________ **CELL PHONE** __________________ **EMAIL** ______________________

PREFERRED PHARMACY ____________________ **EMPLOYER** __________________ **WORK PHONE** ________________

SPOUSE/PARENT ____

PRIMARY INSURANCE CO ______________________________________

ID # ______________________________ **GRP#** __________________

SUBSCRIBER NAME ______________________________

DATE OF BIRTH ______________ **RELATIONSHIP:** __________________________

SECONDARY INSURANCE CO ______________________________________

ID # ______________________________ **GRP#** __________________

SUBSCRIBER NAME ______________________________

DATE OF BIRTH ______________ **RELATIONSHIP:** __________________________

ASSIGNMENT AND RELEASE

For Private Insurance / Medicare Part B / MVA / Work-Related Injury, I the undersigned certify that I (or my dependent) have insurance coverage with ______________________________ and assign directly to Sequim Medical Associates PLLP all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize Sequim Medical Associates PLLP to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

SIGNATURE ____________________________________

DATE ______________________

(OVER)

Sequim Medical Associates, PLLP

840 N 5th Avenue, STE#2100 Sequim, WA 98382 Office (360) 582-2850 Fax (360)582-2851

Patient Name: ____

Date of Birth: _____/____/_____

EMERGENCY CONTACT

NAME: ____ **PHONE:** _________________________

RELATIONSHIP ____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse:_____________________________________

[ ] Child(ren):_________________________________Phone:_________________________

_________________________________Phone: _________________________

_________________________________Phone: _________________________

[ ] Other: _________________________________Phone: _________________________

[ ] Other:_________________________________Phone:_________________________

[ ] Information is **not** to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call… [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message.

[ ] please leave a message asking me to return your call.

The best time to reach me is day(s)____________________ between (time)_____________________

Signed: _________________________________ Date: ____/____/_____

Witness: _________________________________ Date: ___/____/______

SEQUIM MEDICAL ASSOCIATES, PLLP
New Patient Intake

Patient Name: ______________________________ Date: ______________

Age: _______

CONCERNS YOU WOULD LIKE ADDRESSED TODAY:

____

____

____

PAST/CURRENT MEDICAL PROBLEMS:

____

____

____

____

____

PAST SURGERIES (list dates):

____

____

____

____

MARITAL STATUS (please circle): Married / Single / Divorced / Widowed Number of children: ____________

CURRENT / PAST WORK: ____

Any occupational exposures or concerns? ______________________________________

HOBBIES & LIESURE ACTIVITIES: ______________________________________

TOBACCO USE: How much? ___________ How many years? _______ If quit, when? _________

ALCOHOL USE: (# and type drinks) ________________________ per day / week / month / year

CAFFEINE: (# and type of drinks per day): ________________________

EXERCISE: (current amount and type): ______________________________________

DIET: ____

FAMILY HISTORY/Living and Deceased (cancers, strokes, heart attacks, health problems / age at death):

Mother: ________________________ Father: ________________________

Brothers: ________________________ Sisters ________________________

Children: ____

Maternal Grandmother: ________________ Maternal Grandfather: ________________

Paternal Grandmother: ________________ Paternal Grandfather: ________________

PLEASE CONTINUE ON BACK…

MEDICINE ALLERGIES (list reaction): ____

____

CURRENT MEDICATIONS (List all Prescription, Herbal, Over the counter):

Medication: Milligram: How often do you take:

Medication: Milligram: How often do you take:

Medication: Milligram: How often do you take:

Medication: Milligram: How often do you take:

Medication: Milligram: How often do you take:

Medication: Milligram: How often do you take:

________ No additional medications such as pain medicines, benzodiazepines (Hydrocodone, Oxycodone, Xanax, Valium, Ambien etc.) have been omitted from the list, as these will not be filled unless you have listed them here. Please initial.

(If more room needed, add on separate paper)

WOMEN'S HEALTH Please Provide Dates: # pregnancies: ________ # live births: _________ Last menstrual period: ________

Date of last Mammogram: ____________ Pap smear: _____________

Hormone replacement: Current / Previous / Never. If stopped, when: _________

HEALTH MAINTENANCE Please Provide Dates:

DEXA / Bone Density scan: _________________ Colonoscopy / Flexible sigmoidoscopy: __________________________

Tetanus (Please Circle) Td / TDAP: __________ Pneumonia Vac: Prevnar 13____________Pnuemo 23_____________

Flu Vac: ___________ Zostavax: __________ Shingrix: 1st Dose____________2nd Dose _______________

Covid Vac 1st Dose:______________ 2nd Dose: ________________ Booster:________________

Last Physical: __________ Routine Labs (cholesterol, etc.): _____________ Last eye exam: ____________________

Cardiac stress testing: ____ Height ______________________

SPECIALISTS: List other physicians you see: ____

____

Do you have an Advanced Medical Directive / Living Will: (Please Circle) YES NO If yes, please provide a copy for our records.

<u>Are you having problems with…</u>? (Check all that apply):

- ☐ fevers
- ☐ chills
- ☐ fatigue
- ☐ weight change
- ☐ vision changes
- ☐ hearing changes
- ☐ runny nose
- ☐ sinus problems
- ☐ cough
- ☐ wheezing
- ☐ excessive snoring
- ☐ chest pain
- ☐ palpitations
- ☐ trouble breathing
- ☐ leg swelling
- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ constipation
- ☐ diarrhea
- ☐ abdominal pain
- ☐ urinary problems
- ☐ vaginal problems
- ☐ sexual problems
- ☐ breast lumps
- ☐ breast pain
- ☐ nipple discharge
- ☐ muscle aches
- ☐ joint aches
- ☐ back pain
- ☐ rashes
- ☐ lumps
- ☐ itching
- ☐ skin changes
- ☐ hair or nail changes
- ☐ headache
- ☐ dizziness
- ☐ weakness
- ☐ numbness
- ☐ tingling
- ☐ stress
- ☐ anxiety
- ☐ depression
- ☐ memory problems
- ☐ trouble sleeping

SEQUIM MEDICAL ASSOCIATES, PLLP

This Agreement describes the terms under which you may participate in the Sequim Medical Associates, PLLP, program.

1. **The Program.** The Program provides *enhanced services* as an adjunct to our health care services, including:

- Regular newsletters
- Unhurried atmosphere
- Health education forums

The physicians who will provide services to Program participants may change from time to time. I wish my primary care physician to be:

☐ Militza Ausmanas, M.D.

☐ Samantha F. Reiter, M.D.

☐ David M. Lewis, D.O.

☐ William N. Hobbs, M.D.

2. **Monthly Fee**. The Monthly Fees for the Program are as follows; please check the appropriate box for your desired status:

☐ Individual 65 years of age or over $100.00

List patient name: ______________________________

☐ Individual 21-64 years of age $85.00

List patient name: ______________________________

You cannot transfer your participation in the Program to any other individual. The monthly fee for your participation in the Program will be increased only after providing you at least 90 days prior written notice.

For your convenience, Sequim Medical Associates, PLLP, will arrange for automatic withdrawal from your bank account or automatic credit card billing of program fees. If you wish to authorize either of these methods please complete the payment authorization card.

The Monthly Fee covers the cost of the enhanced services which are not covered by your health insurance.

3. **Health Care Services Excluded From Monthly Fee**. The Monthly Fee does not cover the cost of any health care services covered by your health insurance. The Monthly Fee does not cover the cost of any health care services if you have no insurance coverage. You and/or your health insurance company will be financially responsible for all health care services received from Program physicians and staff. The Program will bill your health care insurance for those health care services furnished to you and covered by your insurance. Your insurance coverage is as follows:

Primary Insurance:	**Other Insurance:**
COMPANY	COMPANY
NAME OF INSURED	NAME OF INSURED
GROUP NUMBER	GROUP NUMBER
IDENTIFICATION NUMBER	IDENTIFICATION NUMBER

You will notify the Program as soon as possible of any changes in the information listed above. Nothing in this Agreement supersedes or modifies the terms or conditions of any agreements relating to your insurance.

4. **Co-payments**. You will be financially responsible for any co-payments, co-insurance or deductible amounts due under your insurance. Co-payments are due at the time of health care service as required by your insurer. Payment for the amount set forth in the statement is due within 30 days of the date of billing.

You will be billed on a monthly basis for any charges for co-payments (if they were not collected at the time of the health care service), co-insurance or deductibles for health care services already received.

5. **Governing Law**. This Agreement shall be governed by and construed in accordance with the laws of the state of Washington, and if any provision is held to be invalid or unenforceable, the remaining provisions shall nevertheless continue in full force and effect, unless the provisions held invalid or unenforceable shall substantially impair the benefits of the remaining portions of this Agreement.

6. **Termination. You may terminate this Agreement and your participation in the Program at any time upon 30 days prior written notice to the Program**. The Program may terminate this Agreement and your participation in the Program by providing 30 days prior written notice to you, if any of the following occur: you fail to pay the Monthly Fee or charges for health care services when due; you fail to abide by the terms and conditions of your insurance coverage; or you fail to abide by the policies of Sequim Medical Associates, PLLP, and the Program. In addition, Sequim Medical Associates, PLLP, may terminate this Agreement at any time on 60 days' prior written notice if the Program is discontinued.

7. **E-mail Communications**. If you wish to receive e-mail communications from your provider, please consider the following information about e-mail communications and sign the consent to electronic communications below:

I understand that e-mail is not a secure medium for sending or receiving potentially sensitive personal health care information. Although communications between patient and physician are subject to confidentiality requirements of Sequim Medical Associates, PLLP, and applicable law, Sequim Medical Associates, PLLP, cannot assure the confidentiality or protection of e-mail communications. E-mail sent to Sequim Medical Associates, PLLP, may be accessed by individuals who are not directly involved in my care (for example, Sequim Medical Associates, PLLP, employees performing system administrative functions). E-mail sent to me may be accessed by others (for example, by my employer if my e-mail address is provided by my employer or by my internet service provider).

I understand that e-mail is not a good medium for urgent or time-sensitive communications. Time-sensitive communications should be handled by direct telephone contact or in person. At the discretion of my physician, e-mail communications may become part of my permanent medical record. I understand the e-mail information described above and authorize Sequim Medical Associates, PLLP, to send electronic mail to me at the following address: ______________________________. I understand that I can revoke this consent at any time.

The undersigned agree to the terms of this Agreement.

CLIENT	**ACCEPTED: SEQUIM MEDICAL ASSOCIATES, PLLP**
SIGNATURE ______________________________	BY: ______________________________
NAME ______________________________	ITS: ______________________________
DATE ______________________________	

PAYMENT OPTIONS

***** A 2.5% convenience fee will be added to credit card transactions*****

PLEASE SELECT ONE: ☐ AUTOMATIC WITHDRAWAL ☐ CREDIT CARD

A. AUTO WITHDRAWAL ACCOUNT: ☐ CHECKING ☐ SAVINGS

ACCOUNT NUMBER: ______________________________

ROUTING NUMBER: ______________________________

BANK NAME: ______________________________

****PLEASE ATTACH A VOIDED CHECK OR SAVINGS DEPOSIT SLIP**

B. *CREDIT CARD:* ☐ *VISA* ☐ *MASTERCARD* ☐ *AMERICAN EXPRESS* ☐ *DISCOVER*

CARD NUMBER: ______________________________ **BILLING ZIP** __________

NAME ON CARD: ______________________________ **EXP:** ______ **SECURITY #** ______

PLEASE SELECT ONE: ☐ MONTHLY ☐ QUARTERLY ☐ ANNUALLY

SIGNATURE: ______________________________ **DATE:** __________

PATIENT TRUST AGREEMENT

This Trust Agreement is made _____, 2024, between ________________________

("Grantor") and ____________________________________, M.D. ("Trustee").

1. Trust Estate. Trustee acknowledges receipt in trust from Grantor of the transfer and delivery of funds in the amount of $_________. *These funds, together with any other funds subsequently transferred to and accepted by Trustee,* for the purposes of this trust, shall constitute the "Trust Estate" and shall be administered by Trustee as provided in this Agreement.

2. Revocation; Withdrawal of Assets; Modification. Grantor reserves the right at all times to revoke this instrument in its entirety; to withdraw from the trust any part or all of the Trust Estate; or to partially revoke or modify this instrument. Any such revocation, withdrawal of assets or modification shall be valid and fully accomplished whenever Trustee shall receive from Grantor written notice thereof.

3. Beneficiary and Distributions. During the term of this trust, Grantor shall be the only direct beneficiary. The purpose of the Trust Estate shall be to pay a monthly fee of $__________ to Sequim Medical Associates, PLLP, for medical services provided by Sequim Medical Associates PLLP pursuant to the Sequim Medical Associates, PLLP, agreement for services (the "Service Agreement") between Grantor and Sequim Medical Associates, PLLP. The monthly fee shall be paid on the tenth day of the month immediately following the month in which the services were provided pursuant to the Service Agreement. Trustee shall distribute all income of the trust to Grantor not less frequently than annually. Upon the death of Grantor, all remaining assets of the Trust Estate shall be distributed by Trustee to the personal representative of Grantor's estate.

4. Powers of Trustee. In administering the Trust Estate, Trustee shall have all of the power, authority and discretion given a trustee under the laws of the State of Washington as amended from time to time, except insofar as they may be inconsistent with express provisions of this instrument, which provisions shall control. Trustee shall deposit and maintain all funds of the Trust Estate in a non-interest bearing account of a bank authorized by federal or state law to do business in Washington and insured by the Federal Deposit Insurance Corporation. The funds shall be placed in an account in which withdrawals or transfers can be made without delay when such funds are required. The funds may be deposited in a pooled trust account with subaccounting that will provide for computation of each beneficiary's allocable share.

5. Withdrawal of Trustee. If at any time the Trustee declines, dies, fails, resigns or for any reason is unable to act as Trustee, the trust shall terminate and the Trust Estate shall be distributed to the Grantor.

EXECUTED by Grantor and by Trustee on the date first above written.

GRANTOR:

TRUSTEE:

, M.D.

SEQUIM MEDICAL ASSOCIATES **Authorization to Obtain Information**

I, ________________________, the *PATIENT / LEGAL REPRESENTATIVE* hereby authorize the following:

Organization/Provider: ____

Address: ________________________________ City ____________________ State _____ Zip ________

Phone #: ________________________ Fax #: ____________________________

TO RELEASE INFORMATION FROM THE HEALTH RECORD OF:

Patient Name: First ______________________ MI __________ Last ______________________________

Previous Name (s): ____

Date Of Birth: ____

Send To: Sequim Medical Associates PH: (360) 582-2850 FAX: (360) 582-2851
840 N. 5th Ave, Suite 2100 Physician Name: ____________________
Sequim, WA 98382

****If more than 30 pages please mail DO NOT SEND VIA FAX****

DATES TO BE OBTAINED
___ Most Recent two years
___ Most Recent five years
___ All dates
___ Specific Dates:
from ___/___/___ to ___/___/___

INFORMATION TO BE OBTAINED	
___ ALL RECORDS	___LAB REPORTS
___ CHART NOTES	___XRAY
___ EKGS	___MEDICATION LIST
___ CONSULTS	___ IMMUNIZATIONS
___ SPECIFIC ITEMS: ______________________________	

FOR THE PURPOSE OF: ☐ Continuing Care ☐ Insurance Billing
☐ Transfer of Care ☐ Other ______________________________

SENSITIVE INFORMATION: I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information relating to such diagnosis, testing or treatment.

DISCLOSURES: I understand that authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that once the above information is disclosed, the information may not be protected by federal privacy laws and may potentially be re-disclosed by the recipient.

REVOCATION: I understand that I may revoke this authorization at any time by notifying the Business Manager at Sequim Medical Associates in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

EXPIRATION: This authorization will expire when the request has been filled.

X____

Patient/Legal Representative Signature DATE

____

Relationship (if other than patient) *PHONE #*