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M. Ryan Gross, M.D.
R.D. Holtzclaw-Swan, M.D.

OLYMPIC
INTERNAL MEDICINE, INC. P.S.

Shafeen Rahman, MD.
Michael B. Steele, M.D.
Mary Hutton Eyer, A.R.N.P.

PLEASE USE BLACK INK ONLY

Olympic Internal Medicine, Inc., P.S., 2620 Wheaton Way, Bremerton, WA 98310 (360)377-3923

A. Patient Information:

Name:_____ **Birthdate:** _____ **Sex:** ☐**M** ☐**F** **SS#**_____

Address:_____ _____ _____ _____
Street address **City** **State** **Zip Code**

Phone:_____ ☐**Home** ☐**Work** ☐**Other** **Phone:**_____ ☐**Home** ☐**Work** ☐**Other**

Do we have your permission to leave medical information on your voice mail? ☐**YES** ☐**NO**

Email: _____ **Occupation:** _____

Employer: _____ **Employer's Phone:**_____

Employer's Address: _____
Street Address **City** **State** **Zip Code**

Preferred Language: _____ **Ethnicity:** ☐**Hispanic or Latino** ☐**Non Hispanic or Latino** ☐**Other/Undetermined**

Race: ☐**American Indian/ Alaskan Native** ☐**Black/ African American** ☐**Native Hawaiian / Pacific Islander** ☐**Asian** ☐**White** ☐**Declined to answer**

Marital Status: ☐**Single** ☐**Married** ☐**Widowed** ☐**Divorced** ☐**Separated**

Spouse's Name: _____ **Spouse's Phone:** _____

Spouse's Employer _____**Address:**_____ **Phone:**_____

Preferred Pharmacy Name: _____ **Pharmacy Phone**: _____

B. If someone other than the PATIENT is responsible for payment, complete the following:

Relationship to the patient: _____ ☐**Same as patient**

Name:_____ **Address:**_____
Street Address **City** **State** **Zip Code**

Phone:_____ **Date of Birth:**_____ **Social Security**_____

Employer: _____ **Address:** _____ **Phone:** _____
Street Address **City** **Zip Code**

C. In case of an EMERGENCY: (please list someone who does not live with you, i.e. a neighbor or relative)

Name:_____ **Phone:**_____ **Relationship to patient** _____

DO YOU HAVE_____**A LIVING WILL**_____**DURABLE POWER OF ATTORNEY FOR HEALTH CARE?**
IF NOT, DO YOU WISH ADDITIONAL INFORMATION? ☐**YES** ☐**NO**

The existence or execution of a living will, durable power of attorney for health care, or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate against an individual.

D. How did you hear about us?:

☐**Family/Friend?** ☐**Newspaper?** ☐**Website?** ☐**Phone Book?** ☐**Hospital Referral Service?**

Do you have any objection to our requesting your old medical records if deemed necessary? ☐**Yes** ☐**No**

NOTICE:
I consent to medical treatment and related services at Olympic Internal Medicine, Inc., P.S. We keep a record of the health care service we provide to you. You may ask us to see and copy that record. You may also ask us to correct that 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, obtain copies of your record or receive more information about your record at 2620 Wheaton Way, Bremerton, WA 98310.

Signature:_____**Date:**_____

INSURANCE INFORMATION

How do you intend to pay? Cash_____ Check_____ Insurance_____ Other_____

Primary Insurance:_____

Subscriber:_____

BirthDate: _____

Relationship to Subscriber: _____

Insured ID: _____

Policy Group: _____

Insured Phone: _____

Company Name: _____

Effective Date: _____

Secondary Insurance:_____

Subscriber:_____

BirthDate: _____

Relationship to Subscriber: _____

Insured ID: _____

Policy Group: _____

Insured Phone: _____

Company Name: _____

Effective Date: _____

Is Medicare your secondary insurance? ☐YES ☐NO

MEDICARE PATIENTS: Our office is a Medicare participating office. We will bill Medicare shortly after your office visit. All claims are assigned and payment will come directly to our providers. Please provide complete information if you have a "Medigap" insurance policy to Medicare as we will send this information to Medicare and bill this insurance directly. You will be responsible for the Part B deductible, co-payment if your secondary policy does not cover these charges and/or non-covered services by Medicare.

ASSIGNMENT OF BENEFITS:
I request that payment of authorized MEDICARE benefits be made on my behalf to Dr. Frederick Dore Jr., Dr. Gary Gretch, Dr. M. Ryan Gross, Dr. Shafeen Rahman, Dr. Michael Steele, and, Mary Hutton Eyer, ARNP for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____
Lifetime Signature of Medicare Beneficiary

OTHER INSURANCE: We will bill any insurance (up to two per patient) if you provide our office with your complete insurance information, including a copy of your insurance ID card(s).

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the provider indicated on the claim. I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. A copy of this signature is as valid as the original.

_____
Signature of Patient

IF YOU HAVE HEALTH INSURANCE OF ANY KIND, WE WILL DO EVERYTHING WE CAN TO HELP YOU OBTAIN YOUR PAYMENT FROM YOUR INSURANCE CARRIER. HOWEVER, THE BASIC RESPONSIBILITY FOR PAYMENT IS YOURS.

LATE ARRIVALS & MISSED APPOINTMENTS (NO-SHOWS)

LATE ARRIVALS

We make every effort to maintain appointment time commitments and we request that you extend the same courtesy to us. We ask that you arrive 10-15 minutes prior to your appointment to review your demographic information and complete any necessary paperwork. If you are running late, please call our clinic to reschedule. We understand that special circumstances can arise, which may cause you to run a few minutes behind. On occasion we are able to work-in late arrivals into the schedule; however, this is at the discretion of our front office staff and providers. If you arrive late for an appointment, to help avoid delays in treatment and extensive waiting times, we may ask you to reschedule.

MISSED APPOINTMENTS (*NO-SHOWS)*

The staff at Olympic Internal Medicine respects your time and we ask for the same courtesy. Missed appointments (*no shows*) affect our ability to provide timely attention to our patients. When a patient does not *show up* for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our clinic at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or *no show*. There is a $50.00 charge for not showing for scheduled appointments. This fee is waived for the first no-show as a courtesy. Repeated cancellations or missed appointments may result in dismissal from the practice.

PROTOCOL FOR NO-SHOWS

The first *no show* will be followed up with a letter in the mail reminding you of our missed appointment policy. If you fail to attend two consecutive appointments, you will be charged a $50 *no show* fee and a second letter will be mailed to you. In addition, a course of action will be determined based on the clinic team's review of your case and individual situation. Repeated cancellations and *no shows* could result in a discharge from our clinic. You are directly responsible for payment of the *no show* fee on or before your next appointment. The *no show* fee cannot be billed to your insurance company.

Patient Initials: _____

Thank you for choosing our office!