PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT'S FULL NAME: _____ **DOB** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
HOME PHONE: _____ **WORK PHONE** _____
LENGTH AT PRESENT ADDRESS: _____ **SS NO:** _____

ADULT PATIENTS:
EMPLOYER: _____ **PHONE:** _____
ADDRESS: _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____

RESPONSIBLE PARTY:** _____ **BIRTHDAY:** _____
ADDRESS: _____ **CITY:** _____
STATE: _____ **ZIP CODE:** _____ **SS NO:** _____
EMPLOYER: _____ **PHONE:** _____
ADDRESS: _____ **CITY:** _____
STATE: _____ **ZIP CODE:** _____

SPOUSE OF RESPONSIBLE PARTY: _____ **BIRTH DATE:** _____
SS NO: _____
EMPLOYER: _____ **ADDRESS:** _____
CITY: _____ **STATE:** _____ **ZIP CODE:** _____
PHONE: _____

PERSON TO CONTACT IN CASE OF EMERGENGY: _____
HOME PHONE: _____ **WORK PHONE:** _____

PATIENT'S PHYSICIAN: _____ **DATE OF LAST EXAM:** _____
REFERRED BY: _____ **REASON FOR REFERRAL:** _____

PREVIOUS THERAPY? _____ **WITH WHOM:** _____

****PLEASE NOTE!! THE PARENT BRINGING A MINOR CHILD TO THE APPOINTMENT IS THE RESPONSIBLE PARTY REGARDLESS OF WHO CARRIES THE INSURANCE. PLEASE COMPLETE FORM ACCORDINGLY.**

INSURANCE INFORMATION

COMPANY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____

ID NO: _____

GROUP NO: _____

INSURED: _____

* *

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Michael Domash, M.D. to:

- Furnish my insurance company with any/all information requested concerning my present claim(s).
- Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my case.

I acknowledge that I am responsible for all charges not covered by my insurance. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees and all court costs. I understand that failure to resolve any outstanding balance may result in my account being referred to a collection agency if it remains delinquent without a response from me.

NOTICE OF INFORMATION PRACTICES

Notice: We keep a record of the health-care services we provide 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 or get more information about it from our office staff. The fees for copying records, searching for records or editing records are as follows:

Copying	$0.65 per page for the first 30 pages $0.50 for each additional page
Searching	$15.00 per search
Editing by the physician personally when required by statute	Basic office visit charge

All copies will be released only upon receipt of payment.

I understand that Michael Domash, M.D. is not a Medicare, Medicaid, Tricare, or Crime Victims provider and that I am responsible for any and all charges incurred. I also understand that these services may be available with a contracted provider. I have disclosed all of my insurance information.

_____	_____	_____
Patient's signature (if 18 or older)	Date	Responsible party signature (if for a minor)

Michael Domash, M.D.

Cascade Center for Wellness, 2215 Broadway, Vancouver, WA 98663 (360) 906-7156

Patient Name: _____ DOB: _____

I understand that Michael Domash, M.D. is not a contracted provider for Medicare, Medicaid, Oregon Medical Assistance Program (OMAP), Oregon Health Plan (OHP), Crime Victims or Labor and Industry. Dr. Domash will not bill any of these agencies

These services may be available through a contracted provider. If you choose a contracted provider, these services will be paid for up to the allowable amount.

PATIENT'S REQUEST AND CONSENT FOR NON-MEDICARE/GOVERMENTAL SERVICES

I provide this Request and Consent to protect my future access to private medical care based on payments using Medical Savings Accounts or other private payment methods. I request and consent that the medical office of Dr. Domash ("this private physician") provide medical services to me outside of the Medicare and other government programs in emergency and non-emergency circumstances. I acknowledge and consent that no documentation will be provided for such services to enable reimbursement from Medicare or other governmental programs.

Neither I nor my heirs, executors, administrators, successors, beneficiaries, or assigns will submit a claim (or request that a claim be submitted) for services provided by this private physician. I acknowledge that such services may fall within the scope of Medicare or other governmental programs, and that I have the right to seek such services from other providers if I wish to obtain reimbursement by the government. I consent that the fees charged by this private physician for such services may be greater or less than limiting charges established by Medicare or other programs.

I hereby acknowledge and consent that this private physician is justified in relying upon this Request and Consent in providing all future services to me, whether during an emergency or not. In the event that I take any action contrary to this Request and Consent which causes administrative or legal expense to this private physician, I will provide reasonable reimbursement.

THIS IS NOT A PRIVATE CONTRACT FOR ANY ITEM OR SERVICE. THE UNDERSIGNED IS NOT OBLIGATED IN ANY MANNER TO OBTAIN ANY MEDICAL SERVICES FROM THIS PRIVATE PHYSICIAN, AND REMAINS FREE TO SEEK MEDICAL CARE FROM ANY OTHER PROVIDER AT ANY TIME. THIS FORM IS CONFIDENTIAL AND MAY NOT BE CONSTRUED TO ALLOW DISCLOSURE OF ANY INFORMATION CONCERNING PATIENT.

I have disclosed all of my insurance information, including any coverage through any of the agencies listed above.

Patient's Name _____

Patient's Signature _____ Date _____

Michael Domash, M.D.
- Office Policies –

This statement contains information regarding my office policies. Please read them and, if you have any questions, please discuss them with me. Your signature at the bottom of this sheet signifies you have read, understood, and agree to abide by these policies, and that you have received a copy of the policies for yourself.

Appointments Your appointment time is held exclusively for you and cannot usually be filled on short notice. **If you fail to keep an appointment, you will be charged for the time as though you attended. For appointments canceled with less than 24 hrs. notice (not including weekends or major holidays) we will bill you 50% of the full fee, no matter what the reason.** Please note that insurance companies will not cover this charge and you will be responsible for covering this fee in full.

Emergencies We are not equipped to handle acute emergencies. If you have a non-emergent problem and wish to speak with me leave a message at the office and I will attempt to contact you as soon as I am able. If you need immediate support for an emergency, you may contact the Crisis Line at (360) 696-9560 or visit the nearest ER. When I am out of town, another clinician will be available again for non-emergent issues.

Fees My fee for professional services to you is $350 for an initial evaluation, $300 for subsequent 50 minute sessions, and $150 for 25 minute sessions. **This is maximum you will be charged if there is no insurance or the insurance does not pay.** Additionally, you will be charged $300 per hour for additional services provided at your request or for your benefit (at the request of an insurance company, attorney, etc.), such as report writing, consultation with other professionals, hospital visits, phone calls with you or others, court appearances, etc. Payment (or co-payment) is expected at the time of the visit unless other arrangements are made. Fees are subject to change.

Insurance We will bill your insurance for our services. We will **assist you but** you are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses. Some things to keep in mind are: Are you currently covered? Am I a provider whose services are paid under this plan? What is your annual deductible? What is the percent of coverage? What is the maximum benefit for outpatient mental health coverage? Remember: You are responsible for bills whether insurance pays or not.

Billing You will be billed monthly for any outstanding balance. P**ayment** by the 15th of the month, according to our written agreement, is appreciated. Should the bank return your check, there will be a $25.00 returned check charge. As a last resort, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

Confidentiality and the Release of Information Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: a) cases of suspected abuse or neglect of a child or elder, b) cases where I believe the client presents a clear and imminent danger to him/herself or to another person, c) cases where a court subpoenas me to testify or subpoenas my records or d) cases where an insurance company is helping to pay your fee and requires information about diagnosis and/or reports about treatment.

HIPAA Notice of Policies and Practices We are committed to preserving the privacy of your personal health information. Additionally, we are required by the Federal law (Health Insurance Portability and Accountability Act, known as HIPAA), and by State law to protect the privacy of your personal information and to offer you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the *HIPAA Notice of Policies and Practices* should you wish to have a complete copy for your records.

Your signature below indicates that you have read this agreement and agree to its terms. Your signature also serves as an acknowledgment that you have received the *HIPAA Notice of Policies and Practices* described above.

_____ _____

Signature **Date**

_____

Please print your name

_____ _____

Signature of financially responsible party if not patient **Date**

_____

Please print your name and relationship to patient