Sara Weelborg, ARNP 1919 70th Ave W, Suite D-1 University Place, WA 98466
360.516.0068

New Patient Enrollment

Patient Information:

Patient Legal Name:_____ PreferredName:_____

Mailing Address:
_____City:_____State:_____Zip:_____

Street
Address:_____City:_____State:_____Zip:_____

Home Phone:_____ CellularPhone:_____

Date of Birth:_____

Sex: F_____M_____Marital Status:___Married_____Single_____Other_____

Employer/Vocation:_____

Financially Responsible Party Information: (If different from patient)

Name:_____Relationship to Patient:_____Spouse___Other_____

Address:_____City:_____State:_____Zip:_____

Phone:_____Date of Birth:_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name:_____Phone:_____

Name:_____Phone:_____

Insurance Verification (Please present insurance card and photo ID at registration)

1) Primary Insurance Company:_____

Relationship of patient to insured: (circle one)____Self_____Spouse_____Child_____Other___

Policy Holder:_____Date of Birth:_____

Employed by:_____

Policy ID#_____ _____Group ID#:_____

Insurance Policies

Payment is due at time of service. Please present your insurance cards to the registration desk. If insurance information is not provided, you will default to a self-pay status. Payment, to include co-pays is required prior to a visit. There will be no exceptions to this policy. You will be asked to reschedule your visit if you do not provide the required information and payment/copayment at the time of

service. Please complete the Insurance Verification form provided. You will need to contact your insurance company at the mental health phone number they provide on your insurance card. You may use the invoice we provide to you to bill your insurance company if you are self-pay. Sara Weelborg ARNP accepts cash, debit and credit cards, and personal checks. At this time, Sara Weelborg ARNP is contracted with Regence BlueShield and Premera Blue Cross of Washington, Tricare (United Behavioral Military and Veterans), First Choice, Kaiser Options PPO, United Healthcare, Medicare, Cigna, and Aetna. Commonly there are several types of health plans under these carriers and it is strongly recommended that the patient contact their plan prior to the visit to inquire about coverage.

My signature below indicates that I hereby assume all financial responsibility for services rendered by Sara Weelborg, ARNP. Sara Weelborg does not negotiate claims with insurance carriers. Reduction or rejection of the claim by the insurance carrier does not relieve the patient of the financial obligation incurred for services rendered. Sara Weelborg will accept the contract rate for the insurance plans she is contracted with and will not balance bill. It is the patient's responsibility to determine whether Sara is "in network" and to be aware of current mental health insurance coverage. It is the patient's responsibility to obtain authorization when required by their insurance company. As a new patient, I agree to pay for services at the time of service. Should my insurance be billed, I understand that I am responsible for the copayment at the time services are rendered. Sara Weelborg, ARNP reserves the right to collect deductibles and coinsurance up-front if the account has been delinquent.

I agree to notify Sara Weelborg, ARNP when I move or change insurance carriers. I understand that I will be responsible for payment of all charges and will be expected to pay for all costs incurred for collections including court costs, attorney fees and collection agency fees incurred. I authorize Sara Weelborg, ARNP to provide my designated insurance carrier all required information concerning my health information for payment purposes. I authorize benefits for insurance claims to be made directly to Sara Weelborg, ARNP. I understand that certain services to be rendered in the practice may not be covered by my insurance carrier. I am financially responsible to Sara Weelborg ARNP for all charges for services not covered by my insurance carrier.

I attest that I have read and understand the above. Questions regarding this policy have been answered to my satisfaction.

Patient Signature:_____ Relationship if not patient:_____

Assignment of Benefits/Medical Release/Consent for Treatment

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. Additionally, I understand that Sara Weelborg is a mandatory reporter of child & vulnerable adult abuse and neglect and is required by law to report threats and/or risk of violence to law enforcement and to possible victims of such violence (updated/expanded WA state law 2016). It is my responsibility to ask for clarification if I have questions about these requirements.

I hereby consent to receive medical treatment, x-ray, or laboratory services, which the provider may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due me to be paid directly to Sara Weelborg, ARNP. This agreement will remain in effect until I choose to revoke it in writing.

Patient Signature:_____Relationship if not patient:_____

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Protected Health Information (PHI) Release
For Family Member(s) and Healthcare Team Members

I,_____give Sara Weelborg, ARNP, my permission to have my protected health information (PHI) released to the following:

List individuals below (examples- family members, primary care providers, counselors)

_____,_____
Name Relationship

_____,_____
Name Relationship

I understand that by signing this agreement, I am giving my permission for the above listed people to receive and discuss my protected health information. I also understand that this release is valid until revoked in writing.

I authorize messages to be left at my contact numbers. Sara Weelborg ARNP will make every effort to minimize sensitive information left on answering services: (circle one) YES NO

I authorize an appointment reminder to be sent to my e-mail address listed here: YES NO

e-mail address:
_____

***E-mail is used for appointment reminders only. Phone texting is not guaranteed to be private. Secure messaging through the health record is encouraged and will be discussed at appointment. Text message informed consent may be discussed with Sara.**

PATIENT HEALTH HISTORY

Patient Name: _____Date of Birth:_____

What are your main health concerns?

_____

<u>Your Past Medical History</u> (Please circle if yes)

Alcoholism	Yes	High Blood Pressure	Yes
Anemia	Yes	High Cholesterol	Yes
Anesthetic complications	Yes	Mental Illness	Yes
Anxiety	Yes	Osteoporosis	Yes
Asthma	Yes	Seizures	Yes
Birth Defects	Yes	Severe Allergies	Yes
Blood Clots	Yes	Stroke	Yes
Blood Transfusions	Yes	Suicide Attempt	Yes
Breast Cancer	Yes	Bowel Disease	Yes
Cervical Cancer	Yes	Heart Disease	Yes
Colon/Rectal Cancer	Yes	Kidney/Bladder Disease	Yes
Crippling arthritis	Yes	Lung Disease	Yes
Depression	Yes	Liver Disease	Yes
Diabetes	Yes	STD	Yes

Growth/Develop Disorder	Yes	Ulcer	Yes
Heart Attack	Yes	Other	Yes
Heart pain/angina	Yes		

Previous Surgeries: **(Date)**

Hospitalizations and Reason: **(Date)**

Current Medications (including over the counter)

Allergies to Medications:

FAMILY HISTORY: (If yes, please indicate who: Parent, Sibling, Grandparent etc.)

Alcoholism	Yes	High Blood Pressure	Yes
Anemia	Yes	High Cholesterol	Yes
Anesthetic complications	Yes	Mental Illness	Yes
Anxiety	Yes	Osteoporosis	Yes
Asthma	Yes	Seizures	Yes
Birth Defects	Yes	Severe Allergies	Yes
Blood Clots	Yes	Stroke	Yes
Blood Transfusions	Yes	Suicide Attempt	Yes
Breast Cancer	Yes	Bowel Disease	Yes
Cervical Cancer	Yes	Heart Disease	Yes
Colon/Rectal Cancer	Yes	Kidney/Bladder Disease	Yes
Crippling arthritis	Yes	Lung Disease	Yes
Depression	Yes	Liver Disease	Yes
Diabetes	Yes	Heart pain/angina	Yes
Growth/Develop Disorder	Yes	Ulcer	Yes
Heart Attack	Yes	Other	Yes

SOCIAL HISTORY:
What is your current/past occupation:

Your current marital status: Single Married Divorced Widowed Partnered Separated
Do you use tobacco? (Circle) Yes No How much?
Do you use alcohol? Yes No Drinks per week
Do you use illicit substances? Yes No
How many caffeinated drinks per day?

Who lives at home with you?
Have you ever been the victim of abuse or a violent crime? Yes No

REVIEW OF SYSTEMS:
CONSTITUTIONAL:
Do you have or have you recently had any of the following: (Please circle if yes)
Weight change Yes
EYES:
Do you wear glasses/contacts? Yes Eye Infections Yes
ENT:
Hearing Changes Yes Hoarseness Yes

RESPIRATORY:			
Cough	Yes	Coughed up blood	Yes
Asthma	Yes	Do you snore?	Yes
CARDIAC:			
Chest Pain	Yes	Shortness of breath	Yes
Swelling in your legs	Yes		
GASTROINTESTINAL:			
Abdominal pain	Yes	Nausea or vomiting	Yes
Diarrhea	Yes	Heartburn	Yes
Constipation	Yes		
GENITOURINARY:			
Blood in urine	Yes	Bladder problems	Yes
INTEGUMENTARY:			
Changes in warts or moles	Yes	Skin problems	Yes
NEUROLOGICAL/PSYCH:			
Frequent headaches	Yes	Recent visual changes	Yes
Weakness	Yes	Dizziness	Yes
Memory problems	Yes		
MUSCULOSKELETAL:			
Joint problems	Yes	Swelling in legs or feet	Yes
Unusual pain in hands or feet	Yes	Stiffness in joints	Yes
HEMATOLOGICAL/LYMPH:			
Fatigue	Yes	Easy bruising	Yes
Lumps under arms	Yes	Frequent infections	Yes
ALLERGIC/IMMUNOLOGIC:			
Recurrent sinus infections	Yes	Seasonal allergies	Yes
ENDOCRINE:			
Thryoid problems	Yes		

FEMALE:
Are you pregnant or is there a possibility that you might be pregnant?_____

PSYCHIATRIC HISTORY:
Have you ever been treated by a mental health professional in the past and if so, when?
_____
_____
_____
_____

Have you ever taken psychotropic medications? (antidepressants, anxiety medications, etc.) Yes No

If yes to above, please write a few brief comments about your experience with past psychotropic medications (such as name, dose, effect, side effects,
etc.)_____
_____
_____
_____
_____
_____
_____

Have you ever been hospitalized overnight for observation or psychiatric treatment? Yes No

Have you ever attempted suicide or intentionally harmed yourself? Yes No

Other
Please comment on the reason(s) you are coming to see me for services and include any additional information you feel would be good for me to know about you._____
_____
_____
_____
_____
_____
_____
_____

I have reviewed Sara Weelborg's **Notice of Privacy Practices**. I understand there is a copy posted on the practice's website as well as available at the office should I wish to revisit it. I agree to direct any questions or concerns about this Notice to Sara Weelborg, ARNP.

Signed:_____

Date:_____