NEW PATIENT REGISTRATION FORMS PACKET

3105 Summitview Ave, Ste C
Yakima, WA 98902
(509) 969-6214 | nourishyakima.com

NOURISH WELLNESS FAMILY REGISTRATION

Contact Information

EMAIL ____

WOULD YOU LIKE TO RECEIVE THE E-NEWSLETTER? **YES** **NO**

MOBILE PHONE (________)__________________________

OK TO SEND:

mobile text notifications?:	Yes	No
voice notifications?:	Yes	No
email notifications?:	Yes	No

OK TO LEAVE VOICEMAIL ON PRIMARY PHONE? **YES** **NO**

HOME PHONE (________)__________________________

WORK PHONE (________)__________________________

PREFERRED METHOD OF COMMUNICATION **MOBILE PHONE** **WORK PHONE** **HOME PHONE** **MAIL** **PORTAL**

PREFERRED LANGUAGE ________________________________

ADDRESS ____

ZIP CODE _____________ — ________ **(OFFICE USE ONLY)** **CITY** ___________________ **STATE** __________

Patient Portal Family Registration

NAME ____ **EMAIL** ____

NAME ____ **EMAIL** ____

Patients

NAME ________________________________ **SEX** _____ **DOB** ________/________/________

NAME ________________________________ **SEX** _____ **DOB** ________/________/________

NAME ________________________________ **SEX** _____ **DOB** ________/________/________

NAME ________________________________ **SEX** _____ **DOB** ________/________/________

Parent Information

NAME ________________________________ **RELATIONSHIP TO PATIENT** ____________________

OCCUPATION ______________________________ **DOB** ________/______/_______

PHONE NUMBER ____________________________

NAME ________________________________ **RELATIONSHIP TO PATIENT** ____________________

OCCUPATION ______________________________ **DOB** ________/______/_______

PHONE NUMBER ____________________________

NAME ________________________________ **RELATIONSHIP TO PATIENT** ____________________

OCCUPATION ______________________________ **DOB** ________/______/_______

PHONE NUMBER ____________________________

NAME ________________________________ **RELATIONSHIP TO PATIENT** ____________________

OCCUPATION ______________________________ **DOB** ________/______/_______

PHONE NUMBER ____________________________

Patient Name:
Date of Birth:

Nourish Wellness

CONSENT TO CARE AND TREATMENT

CONSENT TO TREATMENT: The undersigned, as patient or guardian of patient, authorizes Dr. Yami Cazorla-Lancaster, DO, MPH, MS to medically and/or surgically manage the treatment of the above named patient and provide treatment deemed necessary for the benefit of the patient. I understand such services may include examination, medical and minor surgical treatment, x-ray, laboratory, Immunizations, nutritional and lifestyle recommendations and other medical services performed or prescribed. I am aware that the practice of medicine is not an exact science, and acknowledge that no guarantee or promises have been made as to the result of treatment or examination. I authorize release of medical information that may be necessary for reimbursement from insurers. I've reviewed and will comply with office policies.

CONSENT TO TREATMENT BY STUDENT MEDICAL PROFESSIONAL: In the spirit of paying it forward and a passion training the next generation of caring health professionals, Nourish Wellness may have medical, nursing and pre-medical students observing or participating in the care provided for its patients. I understand that this may include history taking, physical examination and/or performing procedures and other aspects of my care. I further understand that at all times these activities will be under the supervision and approval of my physicians and/or other licensed health care professionals and will be at a level deemed appropriate and necessary by them. I consent to the observation and participation of medical and pre-medical students in the medical care provided for me while I am a patient at Nourish Wellness. I understand that I have the right to decline participation of any student at any time.

____________________________ ____________________ _______
Patient/Person Legally Responsible Relationship to Patient Date

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AUTHORIZATION FOR SURESCRIPTS

I understand that, **Nourish Wellness** uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized by **Nourish Wellness**.

____________________________ ____________________ _______
Patient/Person Legally Responsible Relationship to Patient Date

Nourish Wellness

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

To provide timely and accurate payment to Nourish Wellness for any services furnished to the patient listed above by Nourish Wellness physicians and health care providers:

- I certify that the insurance information that I have provided is accurate, complete and current and that no other coverage or insurance exists.
- I assign my right to receive payment of authorized benefits to Nourish Wellness.
- I request that payment of authorized benefits be made on my behalf to Nourish Wellness for any services furnished the patient listed above by Nourish Wellness physicians and health care providers.
- I authorize Nourish Wellness to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided.
- If my Health Insurance Plan will not direct payment to Nourish Wellness, I agree to forward to Nourish Wellness all health insurance payments which I receive for the services rendered by Nourish Wellness and its health care providers.
- I authorize Nourish Wellness or any holder of medical information about me or the patient listed above to release to my Health Insurance Plan such information needed to determine these benefits or the benefits payable for related services.

I further acknowledge and agree:

- That I am responsible for all charges for services provided to the patient listed above which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- That I agree to pay all charges which are not covered by my Health Insurance Plan or for which I am responsible for payment under my Health Insurance Plan.
- I further agree that, if permissible by law, I will reimburse Nourish Wellness for all costs, expenses and attorney's fees that may be incurred by Nourish Wellness to collect those charges.
- That this financial form with assignment of benefits applies and extends to subsequent visits and appointments at Nourish Wellness

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

______________________________	____________________	________
Patient/Person Legally Responsible	Relationship to Patient	Date

Nourish Wellness, PLLC
3105 Summitview Ave, Ste. C Yakima, WA 98902
509-969-6214

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Dr. Yami Cazorla-Lancaster, DO, MPH, MS, respects your privacy. I understand that your personal health information is very sensitive. I will not disclose your information to others unless you tell me to do so, or unless the law authorizes or requires me to do so.

The law protects the privacy of the health information I create and obtain in providing my care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows me to use and disclose your protected health information for purposes of treatment and health care operations. State law requires me to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of my health care team will be recorded in your medical record and used to help decide what care may be right for you.
- I may also provide information to others providing you care. This will help them stay informed about your care.

For payment:

- I request payment from your health insurance plan. Health plans need information from me about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For health care operations:

- I use your medical records to assess quality and improve services.
- I may use and disclose medical records to review the qualifications and performance of my health care providers and to train my staff.
- I may contact you to remind you about appointments and give you information about treatment alternative or other health-related benefits and services.
- I may contact you to raise funds.
- I may use and disclose your information to conduct or arrange for services, including:
    - medical quality review by your health plan
    - accounting, legal, risk management and insurance services;
    - audit functions, including fraud and abuse detection and compliance
    - programs.

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Your Health Information Rights:
The health and billing records I create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice;
- Ask me to restrict certain uses and disclosures. You must deliver this request in writing to me. I am not required to grant the request. But I will comply with any request granted;
- Request and receive from me a paper copy of the most current Notice of Privacy
- Practices for Protected Health Information ("Notice")
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. I have a form available for this type of request.
- Have me review a denial of access to your health information-except in certain circumstances;
- Ask me to change your health information. You may give me this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your Records.
- When you request, I will give you a list of disclosure of your health information. The list will not include disclosures of third-party payors. You may receive this information with out charge once every 12 months. I will notify you of the cost involved if you request information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give me your request in writing.
- Cancel Prior authorizations to use or disclose health information by giving me a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometime you can not cancel an authorization if its purpose was to obtain Insurance.
- For help with these rights during normal business hours, please contact:

Dr. Yami Cazorla-Lancaster, DO, MPH, MS
3105 Summitview Ave., Ste. C Yakima, WA 98902
P: 509-969-6214

My Responsibilities
I am required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

I have the right to change my practices regarding the protected health information I maintain. If I make changes, I will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting my office to pick one up.

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To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of you protected health information, you may contact: Dr. Yami Cazorla-Lancaster, DO, MPH, MS, ND, LAc. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to Dr. Yami Cazorla-Lancaster, DO, MPH, MS, ND, LAc. You may also file a complaint with the U.S. Secretary of Health and Human Services. I respect your right to file a complaint with me or with the U.S. Secretary of Health and Human Services. If you complain, I will not retaliate against you.

Other Disclosures and Uses of Protected Health Information
-Notification of Family and Others

- Unless you object, I may release health information about you to a friend or family member who is involved in your medical care. I may also give information to someone who helps pay for your care. I may tell your family or friends your condition and that you are in a hospital. In addition, I may disclose health information about you to assist in disaster relief efforts. You have the right to object to this use or disclosure of your information. If you object, I will not use or disclose it.

I may use or disclose your protected health information with out your authorization as follows:

- **With Medical Researchers;** if the research has been approved and has policies to protect the privacy of your health information. I may also share information with medical researchers preparing to conduct a research project.
- **To funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations** (tissue donation and transplant) or persons who obtain, store or transplant organs.
- **To the Food & Drug Administration** relation to problems with food, supplements and products.
- **To Comply With Workers' Compensation Laws** – if you make you makes workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law: -** to prevent or reduce a serious, immediate threat to the health or safety -to public health or legal authorities
  - to protect health and safety
  - to prevent or control disease, injury or disability -to report vital statistics such as births or deaths
- **To Report suspected Abuse or Neglect** to public authorities
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when I receive a subpoena, court order or other legal process, or you are the victim of a crime.

- **For Health & Safety Oversight Activities.** For example, I may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask me to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require me to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, I may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

I keep a record of the health care services I provide you. You may ask to see and copy that record. You may also ask to correct that record. I will not disclose your record to others unless you direct me to do so or unless the law authorizes or compels me to do so.

The **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____ ___________________________
Patient or Legally authorized individual signature Date Time

____ ___________________________
Printed Name if signed on behalf of the patient Relationship to Patient

Authorization to Release Health Information

Patient Name ______________________________ Date of Birth _______________

I authorize: Organization/Person Name _______________________________________
Street Address ____
City, State, Zip ____
Telephone/Fax Number____

To release my protected health information to (or obtain protected health information from):

Nourish Wellness, PLLC
Yamileth Cazorla-Lancaster, DO, MPH, MS
3105 Summitview Ave., ste. 3
Yakima, WA 98902
Office: 509-969-6214
Fax: **1-888-565-2493**

Records Requested: Health care information related to the following treatment or condition:
____

Date range for the information requested:
- ☐ Last year
- ☐ Last two years
- ☐ Specified date range ___________________

☐ I understand that if my record contains information concerning alcohol or drug abuse/treatment, mental health (including pain management or psychiatry records) or sexually transmitted diseases (including HIV/AIDS), such information will be ***included*** in this disclosure. ***Sensitive records require specific patient authorization if the patient is an adolescent, therefore, we request patients age 13 years or older to also authorize release of information.***

☐ I want to ***exclude*** the following:
- ☐ Alcohol or drug abuse treatment
- ☐ Mental Health
- ☐ Sexually transmitted diseases
- ☐ HIV/AIDS

The purpose for this information is for continuity of care with the above named person(s)/organization.

Patient rights: I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when the recipient has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above named person or organization. Release will expire in 90 days from the date signed.

___________________________________ ___________________________
Signature of Patient or Authorized Representative Date

___________________________________ ___________________________
Relationship to Patient Telephone number

____
Patient Signature (if age 13 or older)