Dear New Patient and Family:
Sound Family Medicine welcomes you and is looking forward to caring for you and your family. We strive to provide excellent care at convenient times and locations. Sound Family Medicine has expanded to three locations in order to better meet your healthcare needs:

**Sound Family Medicine at Hartland – Puyallup**
3908 10th Street SE
Puyallup, WA 98374
Near Pierce College and Top Foods
Monday – Thursday 7:30am – 7pm
Friday 7:30am – 5pm

**Sound Family Medicine at Sunrise Medical Campus**
11216 Sunrise Blvd. E, Suite 3-106
Puyallup, WA 98374
Half a mile east of Meridian and 176th Street
Monday – Friday 8am – 5pm
Evening Appointments Available

**Sound Family Medicine at Bonney Lake**
10004 204th Ave E
Bonney Lake, WA 98391
Behind Albertson’s
Monday – Friday 8am – 5pm
Evening Appointments Available

In addition to the above, we offer two walk-in clinics (no appointment needed) called “Sound Same-Day Clinic.” These clinics are located at our Hartland/Puyallup and Bonney Lake offices. Our same-day clinics are urgent care facilities that can help you avoid long waits and high costs of hospital ER visits, and they are a convenient option for sudden illnesses. Your personal healthcare record is available at either of these locations, as we utilize an electronic medical record system (EMR). The same-day clinic hours are as follows:

**Sound Same-Day Clinic at Hartland/Puyallup**
Monday – Thursday 7:30am – 8pm
Friday 7:30am – 6pm
Saturday 9am – 3:30pm
Sunday 1pm – 4:30pm

**Sound Same-Day Clinic at Bonney Lake**
Monday – Thursday 8am – 6:30pm
Friday 8am – 4:30pm
Saturday 9am – 3:30pm
All of our physicians are Board-Certified Family Physicians. Most of our doctors also provide maternity care. In fact, Sound Family Medicine physicians deliver nearly 30% of the babies born each year at Good Samaritan Hospital. We especially enjoy the opportunity to care for the entire family, often several generations, from newborns to grandparents.

Our physicians answer their own after-hours calls (we don't use an answering service), and we have a physician on-call for urgent questions during all hours that the office is closed. You can call 253-380-5440 to contact the physician on-call, or you can call the office at 253-848-5951 to hear this number on our greeting message.

Check out our website and sign up for mySFM. If you would like to learn more about our locations and hours, you can visit our website, www.soundfamilymedicine.com. There, you can watch video bios of our providers, and also find out which type of provider is right for you. You can also learn about our secure patient portal, mySFM, which allows you to schedule appointments online, send/receive messages, retrieve test results, request referrals, submit refill requests, and take advantage of online bill payment.

Our website provides useful healthcare forms, such as Medical Release, Durable Power of Attorney, Permission to Treat Minors, and many more. Additionally, we have provided links to multiple health information sites.

Online, you can view the list of insurance plans that are accepted. Please remember, co-pays and/or deductibles are due at the time of service unless arrangements are made in advance.

We also provide other services. We provide on-site laboratory testing, EKG’s, pulmonary function testing, and well-child and well-adult exams. We can even screen for prostate cancer, and perform a comprehensive preventive health evaluation at physical exams.

To ensure that your first appointment will function smoothly, we ask that you please complete the attached forms and bring them with you to your visit.

We hope that you will take advantage of our services and allow us to serve you, your family, and your friends. Thank you again for choosing Sound Family Medicine as your provider of care!

Sincerely,

Denise Martel, Chief Executive Officer
Our relationship with you is one we value and feel that, as with any relationship, it is good to revisit our agreement and expectations of one another periodically. As regulatory and insurance coverage changes have occurred over recent years, Sound Family Medicine has made some changes to our financial and administrative policies. We are hereby notifying you of recent changes and reminding you of other policies which may impact you, our patient and customer. We believe that this communication and these associated policies will help provide a better experience for you and will help expedite the check-in process. The following are policies which may affect you, our valued patient:

**Deductibles, Coinsurance and Copays**
Your insurance policy is a contract between you and your insurance carrier, and not one which SFM has control of. Policy benefits/requirements vary greatly from one carrier/plan to another. It’s important that you review and understand your insurance benefits because some services may not be covered. In addition, your health insurance plan mandates that you are financially responsible for all deductibles, coinsurance, co-pays and non-covered services. Sound Family Medicine is contractually obligated to collect these fees and we are not able to waive them for any reason.

At the start of the New Year, most deductibles reset and, as employers and carriers strive to reduce overall healthcare costs by increasing “healthcare consumerism,” most deductibles are on the rise. Since patients are increasingly becoming financially responsible for a larger portion of their medical charges, we need to make adjustments in how we receive payment for the services we provide. This is especially important when deductibles reset and we know that patients will be financially responsible for the majority of their charges. One change you’ll notice this year is that we will be reviewing transactions from insurances and will be collecting applicable deductible and copay amounts at the time of service, rather than mailing you a bill.

**Health Savings Account (HSA)**
Many companies are now offering a Health Savings Account (HSA) in conjunction with their high-deductible health plans. The federal government created HSA’s so that individuals covered by high-deductible health plans could receive tax-preferred treatment of money saved for medical expenses. When you receive services at SFM, you can use your HSA debit card to pay for out-of-pocket expenses such as copays and deductibles. All you need to do is present your HSA debit card for payment just as you would with a standard debit/credit card. To learn more about HSA’s, please visit the IRS website or contact your employer’s benefits coordinator.

**Identification**
At SFM, we take your privacy and security seriously. In order to prevent fraud, it is important that we are able to properly identify our patients each time they are seen at SFM or pick up prescriptions/health records. We ask that you please have your identification available, upon request, to confirm your identity and protect your information.

**Insurance Cards**
In order to process your medical claims accurately, we also ask that you bring your insurance card with you to each visit and have it available upon request. This provides us the opportunity to confirm the details and identify any errors that may cause your medical claim to be denied.

**Third-Party Billing**
It is sometimes necessary for SFM to acquire services from third-parties in order to meet some of your healthcare needs. The most common third-party services we use are laboratory and pathology testing. This means that you may receive a bill directly from a third-party for services provided as a part of your visit and care at SFM.

Medicare
Patients with Medicare coverage are asked to sign an Advanced Beneficiary Notice (ABN) when receiving certain services at SFM. We are required to have patients sign the ABN for services that may not be deemed medically necessary by Medicare; therefore, not covered. The ABN allows patients to know, in advance, what the medical service(s) may cost them if Medicare denies the claim.

Medicaid
One of the most common Medicaid questions we receive is “Which managed care plan should I choose?” The answer is that Molina is the only managed care plan we are able to accept at Sound Family Medicine. If you are currently enrolled with another plan such as Healthy Options, Basic Health or Community Health Plan, you will need to switch to Molina in order to continue receiving care at SFM. If you arrive for an appointment and have a managed care plan other than Molina, you will be asked to utilize our Prompt Pay program until your plan has been changed.

Prompt Pay
If you have no insurance, you may participate in Sound Prompt Pay (formerly Simple Care), a discounted medical program. Through the Sound Prompt Pay program, patients that pay in full at the time of service are able to realize a discounted price by eliminating the administrative costs of billing an insurance and/or sending patient statements.

Under our Prompt Pay program, patients are charged a flat fee of $85 per visit, payable by cash or debit/credit card. We do not accept checks as a method of payment for Sound Prompt Pay fees. Should your visit become more complex and require significantly more time than a standard visit, your provider may charge an additional $20 at his/her discretion. Any additional services provided at your visit, such as laboratory services, will be charged in addition to the visit fee.

Behavioral Health and Procedure Appointments
At SFM, we understand that sometimes circumstances beyond your control may result in missing or arriving late to your scheduled appointment. In consideration of this, we do extend a short grace period for appointment arrival times, as our schedules allow. If you arrive late for your appointment with our behavioral health specialist, Dr. Colin Daniels, or for your scheduled procedure, your provider will determine whether or not we will be able to still provide your care on that day.

If you are scheduled for a procedure or to see our behavioral health specialist and are unable to keep your appointment, you must notify us of the cancellation at least 24 hours in advance of the appointment time. If you do not notify us within 24 hours prior to the appointment, you may be assessed a $50 no-show fee. Any no-show fee assessed to your account will need to be paid prior to being rescheduled.

Signature ________________________________________ Date __________________
Print Name ______________________________ Relationship to Patient ______________
### PATIENT INFORMATION

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<th>Name</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<th>Cell Phone</th>
<th>Email</th>
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<th>Gender:</th>
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### EMERGENCY CONTACTS

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### RESPONSIBLE PARTY

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<th>ZIP</th>
<th>Home</th>
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### PRIMARY INSURANCE

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<th>Company</th>
<th>Relationship to Patient</th>
<th>Insured ID</th>
<th>Policy Group</th>
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### HOW DID YOU HEAR ABOUT US?

Check all boxes that apply.

- [ ] Billboard
- [ ] The News Tribune
- [ ] Bonney Lake Courier
- [ ] Eatonville Dispatch
- [ ] TV Commercial
- [ ] Yellow Pages
- [ ] Online Yellow Pages

### RELEASE OF BENEFITS AND INFORMATION

I consent for medical treatment and I have verified the insurance listed on this slip and authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or the insurance company to release any information required for this claim. I have read and understand the office insurance/payment policy stated above.

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Health Insurance Portability and Accountability Act

We keep a record of the Health Care Services we provide you and are required by state and federal law to keep this information confidential. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so in writing or unless the law authorizes or compels us to do so. You may see your records or get more information about them by contacting our Medical Records Department.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. It is available for view at all of our locations and you may receive a copy upon request.

By my signature below, I acknowledge I have reviewed SFM’s Notice of Privacy Practices and my questions and concerns have been addressed.

Patient’s Signature  Date

Representative Signature If Patient Is Under 13 Years of Age  Relationship to Patient

OPTION FOR RELEASE

*Must be completed by all patients 13 years of age and older*

**If option below is marked, patient must fill out an Authorization to Release Health Care Info**

I would like to allow access to my protected health care information as defined in the Notice of Privacy Practices to the following people. Without my permission, these people will not be granted verbal or written information regarding my protected health care information.

_____ Spouse
_____ Parent
_____ Other  Relationship to Patient ________________________________

SPECIFIC CONFIDENTIAL CONTACT REQUEST

I would like all communications regarding my confidential health care information conveyed to me in the following manner/at the following location:

Via Mail to this address: __________________________________________

Via Phone at this number: __________________________ OK to leave a message? ___

Via secure message on mySFM secure website ______ Yes ______ No

*Staff: Please note this preference in the "Contact By" box in patient tab of Demo information in CPS and in EMR registration info. If mySFM is selected, please advise patient they must register to receive communications*

revised 2/1/2011
Authorization to Use or Disclose Protected Health Information

PATIENT AKA/FKA: ___________________________ Birthdate __ / __ / ______ PHONE: (_____) ___________ ___________ 

ADDRESS ___________________________________ City: ___________________ State: _______ Zip ____________ 

Section A: Medical Information to be released:

□ You may use or disclose health care information recorded in the last 2 years
□ If requesting records other than the most recent 2 years, please specify timeframe here ____________________________
□ Health care information specifically related to the following treatment (e.g., X-rays, bills) or condition-specify date(s):
___________________________________________________________________________________

Section B: Information protected by State and Federal law:

□ Records as indicated above, including HIV/AIDS
□ Records as indicated above, except those check-marked below:
  • HIV/AIDS
  • Sexually Transmitted Disease
  • Mental Health or Illness
  • Drug and/or Alcohol Abuse
  • Reproductive Care

□ Records as indicated above, including HIV/AIDS
□ Records as indicated above, except those check-marked below:
  • Sexually Transmitted Diseases
  • Mental Health or Illness
  • Drug and/or Alcohol Abuse
  • Reproductive Care

Minors – a minor’s signature is required in order to disclose information related to reproductive care (at any age), sexually transmitted diseases (14yrs and older), HIV/AIDS (14yrs and older), drug and/or alcohol abuse (13yrs and older), and mental health or illness (13yrs and older).

Section C: Disclosure Details:

Please obtain my health care information FROM: Sender Name: ___________________________ Address: ____________________________________________ City State Zip: ___________________________ Phone: ____________________ Fax: ____________ 

Please disclose my health care information TO: Recipient Name: ___________________________ Address: ____________________________________________ City State Zip: ___________________________ Phone: ____________________ Fax: ____________

This authorization ends: □ on (date): ___________________________ □ when the following event occurs (death, age, etc) ___________________________ 

Purpose of disclosure: □ Attorney □ Insurance □ Doctor □ Personal □ Transfer of Care □ Other ___________________________

Requested form of records: □ Electronic disk □ Printed □ No records at this time (Authorization for future requests or verbal disclosure) 

Delivery Method: □ Pick up at ________________________ □ Mail □ MySFM Portal-(only limited records can be submitted to the portal. If we are unable to satisfy this request we will contact you to receive your records alternatively)

Section D: Authorizing Signature:

My Rights:
1. I understand that I’m not required to sign this authorization in order to receive health care services and benefits. However, I do have to sign an authorization form to receive research-related treatment in connection with research studies or to receive health care when the purpose is to create health care information for a third party.
2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by Sound Family Medicine in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   • Fill out a revocation form (a form is available from Sound Family Medicine) or write a letter to Sound Family Medicine.

Protection after Disclosure: I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

Patient or legally authorized individual signature ___________________________ Date ___________ Time ___________

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative) ___________________________

-------------------------------Internal Use only-------------------------------

Records Rec’d by ___________________________ WSDL/ID#: ___________________________ Verified by ___________________________ Date ___________