Qliance

Registration
Child

Patient Information

Last name:	**First name:**	**MI:**	**DOB:**	**O Male** **O Female**
Home address:	City:	State:	ZIP:	
Billing address: ☐ *Same as home.*	City:	State:	ZIP:	
Phone #1: ( ) O Home O Work O Cell	Phone #2: ( ) O Home O Work O Cell			
Email Address:	*I authorize Qliance to email me regarding my medical care:* O No O Yes			
Employer:				
Emergency contact:	Phone: ( )	Relationship:		
Known allergies:	Current Medications:			
Do you take medications regularly for pain, anxiety, sleep or ADD? O Yes O No				

Please Note: *If you are taking a controlled substance regularly for any of these conditions, please see our controlled substance policy at www.Qliance.com or request a copy from Member Services to make sure that Qliance is right for you.*

Membership

Membership Start Date: *(Upon receipt unless otherwise specified.)*	**Qliance Service Level:** O Level 1	
Preferred clinician and clinic location:	O Downtown Seattle O Kent Station O Bellevue O Tacoma	
How did you hear about Qliance?	O Personal Referral:	O TV/Radio:
O Internet:	O Print Publication:	O Other:
Do you have medical insurance? O Yes O No	*If yes, please bring your ID card to your first visit so that we may expedite referrals and outside lab testing.*	

Billing

Billing Frequency: O Annually O Semi-Annually O Quarterly O Monthly

- **OPTION A: Credit Card or Debit Card**

Name on card:		
Card type: O Visa O MasterCard O American Express	Card number:	Expiration:
Card billing address: ☐ *Same as home.*		
☐ *Yes, please add me to the billing account of an existing Qliance patient associated with the above credit card:*		

- **OPTION B: Automatic Funds Transfer**

Please note it takes approximately 3 days from the payment processing date before the charge posts to your bank account.

Name on account:	
Bank name:	Account type: O Checking O Savings
Account number:	Bank routing number: *(please attach a voided check to this form)*

Authorization

Your monthly care fee covers the services specifically described in the Qliance Patient Services Guide. At times, however, your care may require durable medical supplies or third-party services that are not covered by your monthly care fee. To streamline your appointment check-out, please note that by providing the above billing information you authorize Qliance to automatically charge your card or draw on your bank account for any incidental items at the time of service. In all cases, incidental items are charged at or near our cost and will be discussed with you in advance.

- By signing below, I hereby authorize Qliance to contact me using the information I have provided above. By signing below, I hereby authorize Qliance to initiate charges to my credit card, debit card or bank account for my periodic membership fee and any incidental fees that I incur or have incurred on my account since my last billing date. I understand that the transaction amount is the total of my care fee plus the care fees of any individuals on my account.
- This authorization to perform periodic charges to my credit card, debit card or bank account will remain in full force and effect until Qliance has received written notification from me of its termination in such time and in such manner as to afford Qliance and my financial institution a reasonable opportunity to act on it.
- I understand that my participation in Qliance is continuous and that, by signing below, I authorize recurring credit/debit card charges.
- I understand that a $25 fee will be charged to me for declined credit, debit card or automatic funds transfer transactions that are not honored.

ACCOUNT HOLDER SIGNATURE: **DATE:**

OFFICE USE ONLY					Date:
Patient number:	Billing number:	Registration fee: $	☐ MRT	☐ MHF	

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Terms

Patient Agreement & Disclosure Statement

- I acknowledge and understand that I am voluntarily becoming a Qliance Medical Group of Washington PC ("Qliance") patient and that this agreement is non-transferable.
- I have reviewed the *Qliance Patient Services* guide and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that **this agreement does not provide comprehensive health insurance coverage** nor is it a contract of insurance and that **it provides only the health care services specifically described** in the *Qliance Patient Services Guide*.
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of Qliance including but not limited to emergency room, hospital and specialty services and that Qliance will not bill insurance carriers for any services provided by Qliance.
- I acknowledge and understand that Qliance must maintain a record of my health information and must protect the privacy of my health information as per the terms of the *Notice of Privacy Practices*. I understand and acknowledge that this policy is available for my review at any time at www.Qliance.com or upon request.
- I acknowledge and agree to pay my monthly care fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged a $25 late fee and that my service agreement may be terminated.
- I acknowledge and understand that I may terminate this *Patient Agreement* at any time and for any or for no reason by providing written notice to Qliance. **Monthly fees will continue to accrue until written termination notice is received.** Any pre-paid monthly care fees will be prorated to the date Qliance has received my written termination and refunded to me within ten (10) business days.
- In addition, I acknowledge and understand that Qliance may terminate this *Patient Agreement* by providing me written notice and any pre-paid monthly care fees will be prorated to the date of termination and refunded to me within ten (10) business days. Qliance will not terminate this *Patient Agreement* solely on the basis of health status.
- I acknowledge and understand that Qliance may add or discontinue services or may increase my fee schedule at any time (but no more than once per year), and that I will be given, in writing, at least sixty (60) days notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the *Medicare Opt-out Agreement* for review and signature before my first appointment. *(The Opt-out Agreement does not prevent me from receiving current or future Medicare benefits from non-Qliance providers; neither I nor my Qliance health care provider(s) will seek reimbursement from Medicare for the medical services I receive from Qliance.)*

Rights & Responsibilities

- I understand that I have the right to choose my personal health care clinician and to change my clinician at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new clinician's patient panel is open to new patients.
- I understand that I have the right to receive accurate and easily understood information about Qliance's health care services, health care professionals and health care facilities. If I speak a language different from my clinician, have a physical or mental disability or do not understand something, I understand that Qliance will make its best effort to provide assistance so I can make informed health care decisions. If I require interpreter services beyond what can be provided by Qliance, professional interpreters may be provided at an additional cost to me.
- In the event of membership termination, I understand that **I must complete a written Service Cancellation Form**. Any differences in payment between my billing date and the date of cancellation will be refunded to me via the payment method I have chosen for my monthly care fee. I understand that if my account is overdue, I am responsible for resolving the outstanding balance prior to my service cancellation.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Qliance health care clinician (s). I also understand that I am responsible for communicating clearly and respectfully with my clinician. Should I become dissatisfied with my care or Qliance services, I agree to notify Qliance immediately so my concerns may be addressed in a timely manner.
- I understand that I have the right to know all of my treatment options and to participate in my health care decisions. Parents, guardians, family members or other individuals whom I designate may represent me if I cannot make my own decisions.
- I understand that I have the right to speak in confidence with my Qliance provider(s) and to have my health care information protected. I understand that Qliance will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider(s) amend my record if I feel it is inaccurate or incomplete by contacting the Qliance HIM Department.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care clinician(s) or any other staff, including complaints about wait times, operating hours, conduct of personnel, business practices, and adequacy of health care services and facilities. I agree to first bring any complaints to the attention of Qliance staff and to participate in the Qliance complaint and grievance process. Unresolved complaints may be brought to the attention of the Office of the Insurance Commissioner for the State of Washington by calling the Consumer Advocacy department at: (800) 562-6900 (TDD 360-586-6241) or by email at cad@oic.wa.gov.
- In order to receive the best possible care, I agree to be actively involved in my health care decisions and to disclose all relevant information to my Qliance health care clinician(s) so that they can help me achieve my health goals. I also agree to inform my Qliance health care clinician(s) of any health care services I receive outside of Qliance (such as emergency room, specialist, or hospital services).
- I understand that I am responsible for not exposing myself or others to disease or danger. I understand that I can receive information from my Qliance health care clinician(s) about protecting the health and safety of myself and others.

By my signature below, I agree to become a Qliance Medical Group patient & I agree to the terms outlined in this Patient Agreement.

SIGNATURE: **DATE:**

PRINT NAME: **SIGNATURE BY: O Patient O Parent O Legal Guardian**

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Health History Form
Child

NAME:	DOB: *mm/dd/yyyy*	DATE:
Mother's name:	Father's name:	Other parent's name:
Who does your child live with?		

Health Assessment

What is most important to you about the medical care of your child? *(e.g. communication, prevention, wellness planning)*
What specific concerns about your child would you like to address with their new clinician?

Medications & Allergies

Please list all your child's current medications *(including vitamins & supplements).*				
Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				

Allergies to medications and other items:		
1.	Reaction:	
2.	Reaction:	
Preferred pharmacy:	Phone:	Fax:
Address:		

Social History & Lifestyle

Daycare/Nanny? O Yes O No	School:	Grade:
Any problems at home/school/daycare *(i.e. learning, behavioral etc.)?*		
Who lives at home with your child?		
Are there any pets in the home? O Yes O No If yes, type:		
Diet *(infants):* O Breastfeeding O Formula O Solid foods		
Diet *(children or adolescents, please describe):*		
Exercise or Activities		
Type:	No. of days per week:	
Type:	No. of days per week:	
Type:	No. of days per week:	
Does anyone smoke in the home? O Yes O No		
If your child is less than 4'9", does he/she use a car seat (booster seat)? O Yes O No		
If your child is under age 13, does he/she ride in the back seat of the car? O Yes O No		
Do you feel safe in your neighborhood? O Yes O No		
Are there guns in your home? O Yes O No	If yes, are they unloaded and locked away? O Yes O No	
Is there any history of abuse in your child's home or life *(physical, sexual, emotional, neglect)*? O Yes O No		

Continued on page 2

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NAME:	DOB:

Health Maintenance & Prevention

When was the last time your child:	
Had a well-child exam?	Visited the dentist?
Female Health	
Has your child started her period? O Yes *(Age)* O No	
Has your child had a PAP smear? O Yes O No	
If yes, when? *mm/yyyy*	Result: O Normal O Abnormal
Immunizations	
Are your child's immunizations current? O Yes O No	

Personal Medical History

Pregnancy complications:			Delivery complications:		
Delivery method: O Vaginal O C-section			Birth weight:		
Multiple births *(twins):* O Yes O No					
Has your child ever had any problems with the following: *(If yes, please explain.)*					
☐ Alcohol or substance abuse:			☐ Lungs:		
☐ Cancer:			☐ Metabolism *(diabetes, thyroid etc.):*		
☐ Blood:			☐ Muscle, joint, bones:		
☐ Digestion:			☐ Nerves and brain:		
☐ Ear, nose, throat, eyes:			☐ Skin and hair:		
☐ ER Visits:	Type:	Date:	☐ Sleep:		
☐ Heart or blood vessels:			☐ Social, mental or emotional health:		
☐ Hospitalizations:	Type:	Date:	☐ Surgeries:	Type:	Date:
☐ Infectious diseases:			☐ Female health *(menstrual problems, etc.):*		
☐ Kidneys or bladder:			☐ Male health *(testicular lump/pain):*		
☐ Learning disabilities:			☐ Other:		

Family Medical History

Please indicate any family members who have had the following:		
☐ Alcohol abuse:	☐ Bleeding disorders:	☐ Deafness:
☐ Arthritis:	☐ Breast cancer:	☐ Dementia:
☐ Asthma:	☐ Cancer of an unknown type:	☐ Depression:
☐ Autism:	☐ Colon cancer:	☐ Diabetes:
☐ Bipolar disorder:	☐ Cystic fibrosis:	☐ Glaucoma:
☐ Heart attack:	☐ Lymphoma/Leukemia:	☐ Schizophrenia:
☐ Heart disease:	☐ Osteoporosis:	☐ Sickle cell anemia:
☐ High blood pressure:	☐ Ovarian cancer:	☐ Skin cancer:
☐ High blood cholesterol:	☐ Obesity:	☐ Stroke:
☐ HIV:	☐ Parkinson's disease:	☐ Substance abuse:
☐ Inherited anemias *(i.e. thalassemia):*	☐ Prostate cancer:	☐ Thyroid:
☐ Inflammatory bowel disease *(e.g. Crohn's disease):*		☐ Other cancer:
☐ Any other condition that two or more relatives have?		

Please attach your child's immunization record to this form.

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Health History Survey

Optional

This section describes the care your child received prior to joining Qliance. Please score the following questions using a scale of 0-10, with 0 being strongly disagree and 10 being strongly agree. These questions are *optional* and the answers you provide are confidential.

	Score (0-10)
My child has been able to get care from his/her primary care clinician when and how they need it.	
My child has had a personal health care provider (doctor, nurse practitioner etc.) who knows them as a person.	
The bulk of my child's health care needs have been met by their primary care provider's office.	
My child's primary care clinician has coordinated their care throughout the health care system.	
When my child has visited their primary care provider's office, it has been organized and efficient.	

Patient Self Health Assessment

How do you rate your child's health? O Poor O Fair O Good O Very Good O Excellent

During the past 4 weeks, how much trouble has your child had engaging in their usual activities because of their physical or emotional health?

O No difficulty O A bit of difficulty O Some difficulty O Much difficulty O Could not engage in usual activities

During the past 4 weeks, how much school or activities has your child missed due to physical or emotional problems?

O Not at all O 10-20% O 21-30% O More than 30%

During the past 4 weeks, has your child's physical or emotional health limited their social activities?	O Yes O No
In the past 3 months has your child had any injury or illness that has kept them in bed for all or most of the day?	O Yes O No
In the past year, has your child gone to the ER for care?	O Yes O No
In the past year, has your child stayed in the hospital overnight or longer?	O Yes O No

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AUTHORIZATION TO EMAIL PROTECTED HEALTH INFORMATION

Although secure electronic messaging is preferred to unsecure email messaging for communication of protected health information, unsecure email communication containing sensitive health information can be sent between a Qliance provider and patient. If this form is completed and signed by the patient, then unsecure email communication about the patient's medical care and treatment may be used to transmit information between the patient and Qliance.

☐	Authorize email communication I authorize the Qliance Clinical Staff to email me regarding the course of my medical care, treatment and diagnostic test results, excluding information concerning mental health, substance abuse and sexually transmitted disease. ☐ *I further authorize the disclosure of information related to mental health, substance abuse and sexually transmitted disease* Patient/representative's email address (*please print*): ___________________________________ **Signature required on next page**
☐	Change email address I am changing the email address to be used for communications with Qliance. New email address (*please print*): ____ **Signature required on next page**
☐	Discontinue email communication I no longer wish to communicate via email. **Signature required on next page**

- I understand that any email transmission between my provider and me/the patient will become part of my medical record. These email transmissions may be disclosed in accordance with future authorizations.
- I understand that I have the right to revoke this Authorization at any time by indicating so above. If I want to revoke this authorization, I must do so in writing and address it to the entity that I had previously authorized to disclose my information. I understand that if I revoke this Authorization, it will not apply to any information already released as a result of this authorization.
- I understand that this Authorization is voluntary and that I may refuse to sign it. I also understand that the institutions or individuals named above cannot deny or refuse to provide treatment, payment, membership or eligibility for Qliance benefits if I refuse to sign this Authorization.
- I understand that, once information is disclosed pursuant to this Authorization, it is possible that it could be disclosed by the entity that receives it for authorized purposes under the HIPAA privacy rule.

Alert for Electronic Communication

Patients and/or personal representatives who want to communicate with their health care providers by email should consider all of the following issues before signing an Authorization to Email Protected Health Information:

1. Email at Qliance can be forwarded, intercepted, printed and stored by others.

Patient ID (*for administrative purposes only*): ________________

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2. Email communication is a convenience and is not appropriate for emergencies or time-sensitive issues.
3. Highly sensitive or personal information should only be communicated by email at the patient's discretion (i.e., HIV status, mental illness, chemical dependency, and workers compensation claims).
4. Employers generally have the right to access any email received or sent by a person at work.
5. Staff other than the health care provider may read and process email.
6. Clinically relevant messages and responses will be documented in the medical record at the provider's discretion.
7. Communication guidelines must be defined between the clinician and the patient, including (1) how often email will be checked, (2) instructions for when and how to escalate to phone calls and office visits, and (3) types of transactions that are appropriate for email.
8. Email message content must include (1) the subject of the message in the subject line (i.e., prescription refill, appointment request, etc.) and (2) clear patient identification including patient name, telephone number and date of birth or patient identification number (if known) in the body of the message.
9. Qliance will not be liable for information lost or misdirected due to technical errors or failures.

I have read and understand the Alert for Electronic Communications and agree that email messages may include protected health information about me / the patient, whenever necessary.

___________________________________ Patient/representative's signature	___________________________________ Today's date
___________________________________ Patient's printed name	___________________________________ Date of birth
___________________________________ Patient representative's name	___________________________________ Relation

Please note that this Authorization is not valid unless completed in full. This Authorization will not expire unless revoked in writing.

Patient ID (*for administrative purposes only*): _______________

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Qliance Medical Management Inc.'s Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Qliance Medical Management Inc. has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Qliance is not required to accept my requested restrictions, but if they are accepted then I understand that Qliance will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at Qliance.

Authorization to Communicate Protected Health Information - Check all that apply:

☐ Qliance may leave a detailed message on voicemail at my home #: (_____) __________________

☐ Qliance may leave a detailed message on voicemail at my cell #: (_____) ____________________

☐ Qliance may speak with another person (spouse, family member) about my medical condition ☐ including / ☐ excluding information related to mental health, sexually transmitted disease, HIV status and reproductive medicine:

Name/Relation: __________________________________ Phone #: (_____) ________________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify Qliance should I change one or more of the telephone numbers listed above.

_________________________ /_____________ _________________________ / ______________________

Signature / Today's Date Patient Name / Date of Birth

____ ____

Representative Name Relation to Patient

For administrative use only:
We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:
☐ Patient declined to sign ☐ Emergency situation ☐ Communication barriers ☐ Other: ____________

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Medical Records Transfer Form

If you would like your medical records transferred between Qliance and another physician, please complete this form and submit it to Qliance. Please complete one form for each physician office from/to which you would like your records transferred.

Patient Authorization

Last Name:	First Name:	MI	DOB: *mm/dd/yyyy*	O Male O Female
Home address:	City:	State:	Zip:	

From/To *(Please circle intended direction)*

Name:			
Address:	City:	State:	Zip:
Phone:	Fax:		

From/To *(Please circle intended direction)*

Name: **Qliance Medical Group of WA**			
Address: **2101 Fourth Avenue, Suite 600**	City: **Seattle**	State: **WA**	Zip: **98121**
Phone: **(206) 913-4700**	Fax: **(206) 913-4710**		

Purpose of Disclosure

☐ Continuing Care	☐ Insurance	☐ Legal	☐ Personal Use
☐ Transfer of Care	☐ Other (please specify):		

Records to Include

This authorization pertains to the disclosure of the record types indicated below between the following dates of service: from ______ to ______ OR
☐ ALL records retained by facility.

☐ Progress notes	☐ Laboratory notes	☐ Immunization records	☐ Operative reports
☐ Hospital records	☐ Imaging reports	☐ Other specified information:	

Disclosure of Sensitive Information

I understand that my health record may contain sensitive information relating to my condition(s). This includes, but is not limited to, information pertaining to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental health services and treatment for alcohol and drug abuse.

By checking this box, I choose to exclude the above types of information from this disclosure. ☐

Terms & Conditions

- I have the right to revoke this Authorization, in writing, at any time by notifying the Privacy Office at Qliance and the health care provider being requested to disclose health information (if applicable). Such revocation will not apply to information that already had been disclosed in reliance on this Authorization.
- I have the right to not sign this Authorization. Qliance will not condition treatments, payment for services or enrollment or eligibility for benefits on whether I sign this Authorization.
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is the potential for this information to be subject to re-disclosure and no longer be protected by these laws.
- I have read and understand this Authorization, have had an opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- Please note, this Authorization expires one (1) year after the date of signature unless otherwise specified:____________________
- **I understand that submitting this Authorization to Qliance will not terminate my membership and that I will continue to be billed for services until I submit a Service Cancellation Form to Qliance.**

SIGNATURE: DATE:

PRINT NAME: SIGNATURE BY: O Patient O Parent O Legal Guardian

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