

PATIENT INTAKE FORM

PATIENT INFORMATION

Name:			DOB: / /
Single	Married	Partnered	# of people in household:
Divorced	Widowed	Other	# of children:
Occupation:			Employer/School:
Travel outside the U.S.? y n			Where/When:
Gender: M F X FTM MTF Q			

CONTACT INFORMATION

Home Address:			
City, State, Zip Code:			
Phone numbers:	home	cell	work
Please circle the numbers at which we may call you regarding confidential information.			
E-mail address:			
Spouse or Partner's Name, if any:			
Emergency Contact:	home phone #:		
Relationship to patient:	work phone #:		
May we send confidential information (e.g., lab results) to your home address?			y n
To your email address?			y n

REFERRALS AND ADJUNCTIVE CARE

Who is your Primary Care physician? Please provide us with your PCP's contact information (name, clinic name, address, and telephone number). Dr. Fasig strongly recommends you have an in-network PCP.

Please list additional health care providers from whom you receive care (name, specialty, and contact information if possible):

How did you hear about Dr. Fasig?	Insurance referral:	Physician referral:
Name of reference:	Patient referral:	Other:

INSURANCE INFORMATION

Dr. Fasig is not contracted with and does not bill any insurance company. Payment is due at time of service – cash, check, Venmo, Zelle, Visa/MC, or HSA/FSA. Dr. Fasig can give you a receipt which lists CPT and ICD-10 codes for you to then submit to your insurance to seek reimbursement. Insurers may reimburse you for a portion of the office visit cost -- please check with your insurer as every insurance plan is different. Blood draws are \$40 (this does not include any lab fees). Cancellation of, or a failure to show for, an appointment without 24 hours notice (by e-mail or voicemail message) will result in a minimum \$80.00 fee.

Upon request, Dr. Fasig will provide you with a good faith estimate as to charges (office visits, consultations, procedures, etc . . .) that will not apply to third-party charges without further consultation.

Dr. Fasig does not bill PIP or L & I claims (these visits would also be out of pocket).

Dr. Fasig does not charge for brief telephone conversations in which we confirm ongoing treatment or relating to administrative matters. However, although diagnosis generally requires an office visit, a telephone or telehealth consultation may be appropriate if you are an established patient and your last visit/consultation was more than two weeks prior. The **minimum** charge for such consultations is \$80 (per 5-10 minutes). Dr. Fasig does not consult with new patients via telephone or telehealth for the first visit. Medical forms / letters are \$80 per three pages (although some will require an office visit).

I, the undersigned, certify that I agree to pay for services rendered the day of the office visit, consultation, phone consultation, telehealth consultation, etc. I understand that I am financially responsible for all charges, including those paid by Dr. Fasig on my behalf (certain labs would require this). I hereby authorize Dr. Fasig to release all information necessary to secure the payment of benefits if I choose to submit forms to my insurance to seek reimbursement. I authorize the use of this signature on all insurance submissions (used for labs, etc.).

Responsible party signature

Date

HEALTH CONCERNS/SYMPOTMS

HEALTH CONCERNS (Please list in order of importance to you)

1.	4.
2.	5.
3.	6.
Are you currently pregnant? <input type="checkbox"/> y <input type="checkbox"/> n # of months:	
Is your condition related to <input type="checkbox"/> work-related injury <input type="checkbox"/> auto accident	
What are your goals for today's visit and for your long-term health?	
What do you expect of your physician?	

SYMPTOMS (Circle any symptoms you have or have had in the last twelve months)

General	Gastrointestinal	Eyes, Ears, Nose, Throat
Chills	Poor appetite	Bleeding gums
Depression	Bloating	Blurred vision
Dizziness	Bowel changes	Crossed eyes
Fainting	Constipation	Difficulty swallowing
Fever	Diarrhea	Double vision
Forgetfulness	Excessive hunger	Earache
Headache	Excessive thirst	Ear discharge
Loss of sleep	Gas	Hayfever
Loss of weight	Hemorrhoids	Hoarseness
Nervousness	Indigestion	Loss of hearing
Numbness	Nausea	Nosebleeds
Sweats	Rectal bleeding	Persistent cough
	Stomach pain	Ringing in ears
	Vomiting	Sinus problems
	Vomiting blood	Sore throat
Muscle/Joint/Bone	Cardiovascular	
Pain, weakness, numbness in:	Arms	Back
	Legs	Feet
	Hips	Hands
	Neck	Shoulders
Genito-Urinary	Skin-related	
Blood in urine	Chest pain	Bruise easily
Frequent urination	High blood pressure	Hives
Lack of bladder control	Irregular heartbeat	Itching
Painful urination	Low blood pressure	Change in moles
	Poor circulation	Rash
	Rapid heartbeat	Scars
	Swelling of ankles	Sores that won't heal
	Varicose veins	Eczema/psoriasis

HEALTH HISTORY

CHEMICAL EXPOSURE

Please indicate any known chemical exposure, past or present, to any of the following toxic substances?

Mercury	Lead	Arsenic
Herbicides/Pesticides	Formaldehyde	Other:

MEDICATIONS & SUPPLEMENTS

Medications & Dosage:	
1.	4.
2.	5.
3.	6.
Supplements (vitamins, herbs, etc...)	
1.	4.
2.	5.
3.	6.

CURRENT/PREVIOUS CONDITIONS

Please indicate any condition(s) you have been diagnosed as having:

ADD/ADHD	German Measles	Mumps
Alcoholism	Glaucoma	Pacemaker
Anemia	Goiter	Pneumonia
Anorexia	Gonorrhea	Polio
Anxiety	Gout	Prostate Problem
Appendicitis	Heart disease	Psychiatric Care
Arthritis	Hepatitis	Rheumatic Fever
Asthma	Hernia	Rubella
Back/Neck Pain	Herpes	Scarlet Fever
Bladder infection	High blood pressure	Schizophrenia
Bleeding disorders	High Cholesterol	STDs
Breast Lump	HIV/AIDS	Strep throat
Bronchitis	Hives or Eczema	Stroke
Bulimia	IBS	Suicide Attempt
Cancer	Infectious Mono	Thyroid disease
Cataracts	Kidney disease	Tonsillitis
Chemical Dependency	Liver Disease	Tuberculosis
Chickenpox	Low blood pressure	Typhoid Fever
Crohn's disease	Lupus	Ulcer
Depression	Measles	Ulcerative colitis
Diabetes	Migraines	Vaginal Infections
Emphysema	Miscarriage	Venereal Disease
Epilepsy	Mitral valve prolapse	Whooping cough
Fibromyalgia	Multiple Sclerosis	Other (please list):

HEALTH HISTORY

Known allergies:			
Iodine	Sulfa drugs	Aspirin	Scents
Penicillin/antibiotics	Local anesthetics	Nuts	Other:
Please describe (indicating the date) any serious illnesses, hospitalizations, or operations:			
Have you ever had a blood transfusion?		y	n
Does your occupation expose you to:		Hazardous substances:	
Heavy lifting		_____	
Standing long hours		_____	
Sitting long hours		_____	
Stress		_____	

EXAM AND IMAGING HISTORY (Indicate date, doctor's name, or place of most recent)

Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Colonoscopy		STD screen	
Prostate check		Cholesterol screen	
TB test		Bone density check	
Other:			

IMMUNIZATION HISTORY

Immunization	Date	Boosters
Tetanus-Diphtheria-Pertussis		
Measles-Mumps-Rubella (MMR)		
Varicella		
Hepatitis A		
Hepatitis B		
Flu shot		
COVID19		
Other (RSV, Shingrix, etc ...):		
Other:		

HOSPITALIZATIONS

Year	Hospital	Reason & Outcome

SOCIAL & LIFESTYLE

Habits	Yes	No	Details
Current Tobacco Use			Packs per day:
Past Tobacco Use			Packs per day:
Quit?			When?
Alcohol consumption Types?			Per day? Per week?
Recreational drug use			Type:
Drug/Alcohol abuse treatment?			When?
Caffeine (coffee, tea, soda)			Cups per day: Type:
Regular exercise? Types:			How much?
Health Hazards at home/work			
Social			
Are you happy with the status of your relationship?	y		n
Do you have a strong support network (family/friends)?	y	n	Who?
What is your predominant emotion?			
Lifestyle			
Do you enjoy your work?	y	n	Hours per week:
Stress level:	low	medium	high
Source of stress:	money	job	family/relationship
What do you do to relieve stress?			

MALE HEALTH INFORMATION

Condition	Never	Past	Current
Difficult urination			
Testicular pain/swelling			
Impotence/sexual difficulties			
Prostate problems			

FEMALE HEALTH INFORMATION

Obstetric / Menstrual history			
Are you currently pregnant?	y	n	# of months:
Have you ever been pregnant?	y	n	When?
Age at first pregnancy?	Number of pregnancies?		
Adopted children?	y	n	When?
Number of tubal pregnancies?			
Number of Caesarean sections?	Date of last pregnancy?		
Difficulty conceiving?	y	n	
Difficulty with pregnancy?	y	n	
Difficulty with labor or delivery?	y	n	
Difficulty with breast feeding?	y	n	
Future OB plans	y	n	

Menstrual history

Date last menstrual period began:	Pain with menses?		
Fibroids/or endometriosis?	Periods regular?	y	n
Days between periods:	Length of flow (days):		
Heaviness of flow:			
Color of flow:			
History of ovarian cysts (if able, provide dates, if ultrasound confirmed, etc.):			
		Clots?	y
		Clot size?	Small
		Medium	Large
		Pain with ovulation?	y
Pain with menses?	y	n	Menopause?
PMS symptoms	None	Acne	Mood swings
	Bloating/swelling	Digestive changes	Headache
	Breast tenderness	Fatigue	Other:

Vaginitis symptoms	Never	Past	Current
Discharge			
Irritation			
Itching			
Odor			
Pain with sex			
Trichomoniasis			
Bacteria (BV)			
Yeast			
Risk Factors			
History of abnormal paps?	y	n	
Did your mother take DES?	y	n	
Long term hormone replacement (> 5 years)?	y	n	

FAMILY HISTORY

Mother:	Living	Age:	Deceased	Cause:
Father	Living	Age:	Deceased	Cause:
Brother	Living	Age:	Deceased	Cause:
Brother	Living	Age:	Deceased	Cause:
Brother	Living	Age:	Deceased	Cause:
Sister	Living	Age:	Deceased	Cause:
Sister	Living	Age:	Deceased	Cause:
Sister	Living	Age:	Deceased	Cause:
Child:	Living	Age:	Deceased	Cause:
Child:	Living	Age:	Deceased	Cause:
Child:	Living	Age:	Deceased	Cause:
Has any family member had:			Which relative?	Age of onset
Diabetes				
Arthritis				
Asthma				
Severe allergies				
Stroke				
Heart disease				
Heart attack				
Blood clots in lungs or legs				
High blood pressure				
High cholesterol				
Kidney disease				
Osteoporosis				
Hepatitis				
Thyroid problems				
Colitis/Crohn's disease				
HIV/AIDS				
Tuberculosis				
Birth defects				
Drinking/drug problems				
Breast cancer				
Colon cancer				
Ovarian cancer				
Uterine cancer				
Other cancer: _____				
Mental illness/depression				
Alzheimer's				
Other: _____				
Other: _____				

I certify that the information provided in this form is correct to the best of my knowledge. I will not hold Dr. Fasig responsible for any error or omission I may have made in the completion of this form.

Patient's signature
2026intake

Date

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS
INFORMATION.
PLEASE READ IT CAREFULLY.**

NOTICE OF PRIVACY PRACTICES

Effective December 8, 2006

The following is the privacy policy (“Privacy Policy”) of Dr. Amy Fasig (“Covered “Entity”) as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity’s legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical

necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include:* (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Covered Entity. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures:* to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the

personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to Dr. Amy Fasig, 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the entity or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes:* (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to 2026intake

disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Dr. Amy Fasig, 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer, Dr. Amy Fasig at 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109; by telephone at 206-599-6030, or by e-mail at dr.amyfasig@gmail.com. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent Dr. Amy Fasig, 2206 Queen Anne Avenue North, Suite 204, Seattle, WA 98109. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer Dr. Amy Fasig at the address, telephone number, or e-mail address listed above.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

Name _____ Date of Birth _____

Signature _____ Date _____

Amy Fasig, ND
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