1950 Pottery Ave, Suite 140
Port Orchard, Washington 98366
(360)876-5440 fax (360)876-0718
www.eppelfamilymed.com
Email: Eppelfamilymedicine@gmail.com

EPPEL Family Medicine Patient Standards

Appointments

To schedule an appointment, please call us at (360)876-5440. Your cooperation in arriving on time for your appointment helps us stay on schedule. We offer same-day sick visits and appointments for patients with minor urgent problems.

New Patients

If you're a new patient with us, please arrive 15 minutes early to your first appointment to complete the necessary forms for enrollment.

Cancellations

If you must cancel your appointment, we would appreciate 24 hours cancellation notice. This allows us of offer the appointment to another patient seeking care. **If you fail to notify us of any cancellation, and you No-Show, we can charge you $45.00 for the Office Visit.**

What to Bring to Your Appointment

- Your current insurance card and ID
- A list of your current mediciations (with dosage), including any over-the-counter medications or supplements
- Any questions you my have for your physician about health concerns, medications and treatments
- Any prescriptions refills you may need, bring names and dosages so we can provide them for you at the time of your visit.

Co-Pays/ Bad Check Charge

All co-pays are due at the time of service. If for whatever reason you were to have insufficient funds to cover a check you wrote to us, an additional charge of $45.00 will be assessed to you to cover the bank charges and bookkeeping costs.

Patient Signature____

Date_____________________________

FINANCIAL RESPONSIBILITY AGREEMENT

I agree to pay for all services provided. I acknowledge and accept that it is my personal responsibility for payment in full for billed charges even where Eppel Family Medicine has been assigned partial benefits (payment). This includes but not limited to: Deductible, Co-Pay, Co-insurance, and any other patient responsibility portion. I acknowledge failure to pay my financial obligations to Eppel Family Medicine may result in the referral of account(s) to a professional collection agency. I consent to Dynamic Collectors Inc. or its affiliates, agents or designees to obtain a copy of my credit report or any other publicly available data related to my ability to pay. In the event of any dispute regarding payment, I agree to pay all collection costs or fees including but not limited to interest and attorneys' fees in the event legal action is taken.

Phone Authorizations: You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and including in any such messages information required by law (including debt collection laws) and / or regarding amounts owed by you; (3) to send you text messages; (4) to use pre-recorded/ artificial voice messages and / or an automatic dialing device (an "autodialer") in connection with any communications made to you or related to your account.

Patient Name Printed   Patient SIGNATURE   Date

New Patient Registration Form

Patient Name:_________________________________Birthdate:_____/_____/_____Gender: M / F

Address:______________________________________ City: _______________________State:_____

Apt/Suite:_____________________________________Zip:___________Email:_________________

Driver's License:________________________________ State:______ Phone:___________________

Secondary Phone:_________________________ Preferred Language:_________________________

Employer:______________________________________ Work Phone:________________________

Responsible Party:_______________________________ Phone:_____________________________

Address:______________________________________ City:____________________ State:_______

Zip:____________ (Military Only) Social Security #:____________________ Sponsor DOB__________

Preferred Contact Method:	**Race: Primary/Secondary**	**Marital Status:**	**Ethnicity:**
☐ Phone ☐ Email ☐ Txt Msg	☐ White ☐ Black or African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Hispanic ☐ Other	☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Legally Separated	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled	**Referred By:** ☐ Another Patient ☐ Another Dr. Office ☐ Insurance Company ☐ Newspaper ☐ Phone Book ☐ Walk-In ☐ Internet Source ☐ Other:___________	**Emergency Contact Information:** Name:__________________________________ Address:________________________________ City:__________________ State:____________ Zip:_________ Phone:_____________________ Relationship to Patient:____________________	

Disclosure & Release:

I authorize treatment of the person named above and understand that I am responsible for payment of this service regardless of insurance coverage or third party agent. I authorize EPPEL Family Medicine to release to my insurance company any information requested in order to expedite the payment of this claim. I also authorize any referring or other physician to release any needed information to assist in treatment and the claim payment process. I authorize payment of medical benefits to EPPEL Family Medicine.

Signature:____ Date:________________________

INFORMED CONSENT

EPPEL Family Medicine Notice of Privacy Practices provides information about how we use and disclose protected health information about you. A copy of this notice is available for you review. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

It is our policy that your health information will only be used or disclosed for the purpose of treatment, payment or healthcare operations. You have the right to request that we restrict how health information about you is used for these purposes; however we are not required to agree to this restriction. If we do, we are bound by our agreement with you.

By signing this form you consent to our use and disclosure of protected health information about you for the purpose of treatment, payment and health care operations. You have the right at any time to revoke this consent, in writing, except where we have already made disclosures in reliance of your prior consent.

Patient Printed Name____

Patient/Guardian Signature _________________________________ Date ___________________________

PROTECTED HEALTH INFORMATION RELEASE

Occasionally, patients need to collect copies of their records. Legally we can only release this information to you or someone authorized by you. If there is anyone else that you would like to have permission to collect records on your behalf please complete the following:

In my absence, the following persons have my permission to collect Protected Health Information on my behalf:

Name____________________________________ Relationship_____________________________

Name____________________________________ Relationship_____________________________

Name____________________________________ Relationship_____________________________

Signature____ Date_____________________

The Revised Notice can be found in the Blue Notebook in the patient waiting room for your reading pleasure. If you desire of copy of the full version, let the front desk receptionist know and we will get you a copy.

Patient Name____

Patient Signature:____________________________________ Date_________________

NARCOTIC PRESCRIBING POLICY

Thank you for choosing Eppel Family Medicine for your health care needs. It is our goal to provide the best possible care for our patients. In order to reach this goal, it is necessary to have rules established to eliminate those who procure narcotics for illegal purposes, or for substance abuse. We must also protect privileges of our practice to prescribe, obey the federal and state laws under which we operate, and maintain the health and welfare of the patients.

Our office policy on the use and prescription of narcotics is as follows:

Refills or new prescriptions for narcotics are only written during scheduled office visits. We cannot call in narcotic prescriptions during non-office hours. We do not fill prescriptions that were lost, stolen, spilled, flushed, eaten by a cat/dog, etc. – NO EXCEPTIONS. The responsibility for safekeeping of these medications lies solely with the patient.

- No narcotics will be prescribed for chronic pain outside of active cancer treatment, palliative care, and end-of-life care.
- Narcotics may be prescribed for acute injuries.
- Narcotics will only be prescribed for a period of two weeks following an acute injury/surgery. There are the occasional exceptions to the rule. In this case we will need to see you to reevaluate your condition prior to renewing your prescription.
- If you are currently on chronic narcotics, we can work with you to wean off the medication or refer you to a pain management clinic.

As part of keeping our patients informed, we want to make you aware of the reasons why we limit the use of narcotics.

- Severe postoperative/post injury pain that would require narcotics will usually reduce significantly by 2-3 days after surgery or injury and is gone by 10-14 days. Need for narcotics longer than this period may signal complications that need more direct or specific treatment instead of covering up the problem. Typically however, it is known that a longer need for narcotics more often than not means that you are up doing too much and “chasing” it with narcotics. Although you may desire to be active, it is possible to be too active after an injury. You need to listen to your body and respond to it. Overall, you will recover quicker reducing your activity so that your pain is controllable without the need for narcotics. After all, your goal is to make the best possible recovery you can.

- After 3-7 days your brain wants to and is supposed to kick in and manage the pain naturally. This is the best way to manage medium and long-term soreness and milder pain. Narcotics are known to block this normal process.
- Narcotics are proven to be habit forming. Dependency on pain medication can start in as little as 2 weeks after beginning their use. We cannot tolerate allowing this to happen.
- The Washington State Medical Society and The Drug Enforcement Administration track providers and their prescribing of narcotics.
- We do not deny that you often have pain; however, it is necessary to be aware of your own ability to tolerate pain. We have created this policy to assist in assuring our patients receive the best care possible and we appreciate your assistance in enforcing it.

We appreciate your trust in us, and thank you for the opportunity to serve your health care needs. If you have any questions regarding our office policy on the use of narcotics, feel free to contact us so we can discuss it. In addition if you feel you need help with long-term (chronic) pain control, we will be happy to refer you to a pain management specialist.

I, ____ have read and understand the prescribing policy above.

___

Responsible Party Signature Date