
**Roger W. Washington MD, Inc.**
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San Jose, CA 95122
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LIC: G52316
*Fellow American Academy of Family Physicians*


## Patient Information

Patient Name: (Last,First)_____ DOB: _____

Address: _____City: _____St: _____ Zip: _____

Primary Phone: _____Secondary Phone: _____

Email: _____ Employer: _____

Please Indicate: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Pharmacy: _____ City: _____Zip: _____

In case of emergency contact:

Contact Name: _____ Phone: _____Relation: _____

## Primary Insurance

Insurance Carrier: _____

Member ID: _____ Group #: _____

Are you the primary insurance holder? ☐ Yes ☐ No

(If, NO) Subscriber Name:_____ D.O.B: ____/_____/_____

## Secondary Insurance

Insurance Carrier: _____

Member ID: _____ Group #: _____

Are you the primary insurance holder? ☐ Yes ☐ No

(If, NO) Subscriber Name:_____ D.O.B: ____/_____/_____

## Assignment & Release

*FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT*

I hereby authorize Dr. Roger Washington to release any information acquired during my examination or course of treatment to the named insurance company for the purpose of billing. I also authorize release of information to my employer if this is a work-related problem. I authorize payment directly to Dr. Roger Washington of any medical benefits otherwise payable to me for his services described, but no to exceed the reasonable and customary charge for these services. It is understood that any payments received from the insurance company over and above any indebtedness will be refunded to me when my bill is paid in full.

I understand that I am financially responsible for all charges not covered by this authorization. I further agree to pay all finance charges, collections cost (40%), Attorney fees, and any other cost that may be incurred to enforce collection of any amount. I authorize Dr. Roger Washington to perform those diagnostic and/or office procedures deemed necessary to evaluate and/or treat my current medical illness(es). I make this authorization with the knowledge that Dr. Roger Washington will verbally describe the nature of said procedures in lay terminology. Including possible complications and side effects and obtain verbal consent prior to procedures. I retain the right to refuse any procedure, either diagnostic or therapeutic, after being informed of its nature, complications and side effects.
I UNDERSTAND THAT FAILURE TO PAY MY CO-PAY AT THE TIME OF SERVICE WILL RESULT IN AN ADDITIONAL 2% ADMINISTRATIVE FEE.

_____ Date: _____
Patient Signature

## Financial Policy Agreement

*Please read and initial for consent on terms.*

_____ **Account Balances:** Full or partial payments due at check-in for all patient accounts.

_____ **Bounced/Returned** Check Fee: All returned checks will incur a $25.00 administrative fee billed to the patient's account.

_____ **Cancellation and No Show Policy:** If it is necessary to cancel your scheduled appointment, we request that you call one (1) working day in advance. A failure to cancel or present at the time of a scheduled appointment will be recorded in your chart as a "no show" and an administrative fee of $50.00 will be billed to your account. Patients with 3 "no shows" will be dismissed from the practice.

_____ **Collections Policy:** All outstanding patient account balances greater than $50.00 will be sent to a third-party collections agency for payments not received within 90 days of services performed. Patient further agrees to pay all finance charges, collections costs (40%), Attorney fees, and any other cost that may be incurred to enforce collection of any amount.

_____ **Co-payments/Co-Insurance:** Due at time of services rendered; exact amount of cash is appreciated, as office carries minimal cash for change. Checks and credit cards (Visa, MasterCard, and American Express) are accepted.

_____ **Finance Charges:** Any patient account with a balance of $50.00 or greater will be assessed a finance charge of 2% for payments not received within 60 days of services performed. **An additional finance charge of 2% will be assessed every 30 days that full payment is not received.

_____ **Insurance:** Your insurance policy is a contract between you and the insurance carrier; the Physician is not involved in this contract. You are contractually responsible for your co-payment, co-insurance, or any balance unpaid at the time of service.

_____ **No Insurance:** Patients who are self-pay are responsible for the entire balance at time of Service.

_____ **Payment Plans:** Any patient with an account balance greater than $50 may set up a payment plan with our office. At minimum, 10% of the total balance must be collected each month.

_____ **Payment Methods:** Roger Washington, M.D. offers several payment methods to help accommodate a patient's financial status.

Patients can choose:

- Provide a credit card for the staff to keep on file. Any account balance will be charged to the card on file monthly.
- Receive monthly statements in the mail and pay the full balance promptly;
- Set up a payment plan with our office. Once established, the patient agrees to adhere to the chosen payment method until her balance is paid in full.

## Financial Policy Consent

Please select preferred account payment method (CHOOSE ONE):

***In an effort to make our billing process easier, faster, and more efficient, Roger Washington, M.D. has implemented a policy to collect credit card information at the time of your visit. Your card information will be held securely until your insurances have paid their portion and notified our office of the amount of your share. At that time, any balance owed by you will be charged to the credit card on file. This will be an advantage to you since you will no longer need to mail in a check, and it will be an advantage to our office since it will greatly reduce billing costs.*

This payment method does not apply to patients who are self-pay patients. Co-pays are still due at the time of service. Should you have any further questions, please contact our office staff.

☐ I prefer to receive a monthly statement in the mail, and I agree to pay the balance in full promptly. I understand that by selecting this choice a $20.00 service fee will be applied for each additional statement that is printed and mailed.

☐ I have an HSA account that should automatically pay my account balance. I understand that by selecting this choice, I will be billed monthly, will promptly pay my balance not paid by my HSA account, and that a $20.00 service fee will be applied if an additional statement is needed to be mailed.

☐ I authorize Roger Washington, M.D. to charge my credit card for account balances remaining after my insurance policy has paid. No statement will be provided. Roger Washington, M.D. will send a detailed receipt within 5 business days of the transaction. If the charge is not accepted by the credit card company a monthly statement as described below will be sent and this selection will be voided until a valid credit card is received.

Visa, MasterCard, American Express (*Please circle one*):

Card Number: _____

Exp. Date: _____ CVV Code: _____

Card Holder Name: _____

Card Holder Signature: _____

I have read and agree to the Financial Policy of Roger Washington, M.D.

Printed Patient Name: _____

Patient Signature: _____ Date: _____

*Thank you for your cooperation!*

## Patient Health History

Date of last Physical Examination: _____ Any Abnormalities? ☐ No ☐ Yes

If Yes, please explain: _____

*Please list the most recent date for each that apply:*

| | | | |
|---|---|---|---|
| Menstrual Period _____ | Digital Rectal Exam _____ | Colonoscopy _____ | Pneumonia Vax _____ |
| Mammogram _____ | PSA Blood Screen _____ | Bone Density _____ | Flu Shot _____ |
| Pap Smear _____ | Cholesterol Testing _____ | Tetanus Shot _____ | Covid Vaccinated? ◯ ◯ |

### Conditions *Please check conditions that are current and prior*

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Chemcal Dependency | ☐ Herpes | ☐ STD |
| ☐ Alcoholism | ☐ Depression | ☐ High Blood Pressure | ☐ STI |
| ☐ Anemia | ☐ Diabetes | ☐ HIV Positive | ☐ Stroke |
| ☐ Anxiety | ☐ Epilepsy | ☐ Liver Disease | ☐ Suicide Attempt |
| ☐ Arthritis | ☐ GERD (Reflux | ☐ Multiple Sclerosis | ☐ Thyroid Problem |
| ☐ Asthma | ☐ Glaucoma | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Bleeding disorder | ☐ Goiter | ☐ Pneumonia | ☐ Ulcer(s) |
| ☐ Breast Lump | ☐ Gout | ☐ Prosate Problem | ☐ Vaginal Infections |
| ☐ Bronchitis | ☐ Headaches | ☐ Psychiatric Care | ☐ Other: _____ |
| ☐ Bulimia | ☐ Heart Attack | ☐ Rheumatic Fever | _____ |
| ☐ CAD /Heart Disease | ☐ Hepatitis | ☐ Rhinitis | _____ |

### Allergies

| | | |
|---|---|---|
| ☐ No known allergies | ☐ Food: _____ | Do you have an Epi- Pen? ☐ Yes ☐ No |
| ☐ Penicillin | ☐ Seasonal | |
| ☐ Latex | ☐ Medication : _____ | |

### Medications

Please list dosage amount and direction of use

## Health Habits *Please check all boxes that apply and describe*

| | | | |
|---|---|---|---|
| Caffeine | ☐ None | ☐ Yes | Drinks Per Day: |

| | |
|---|---|
| Tobacco | ☐ None ☐ Yes ◯ Cigarettes or Vape Pen ◯ Cigarettes Per Day: |
| Alcohol | ☐ None ☐ Yes Drinks per Day Drinks per Week: |
| Drugs | ☐ None ☐ Yes |
| Diet | |
| Excercise | |
| Seat Belts | ☐ Always ☐ Never ☐ Sometimes |
| Blood Transfusion | ☐ No ☐ Yes If yes, date: |

## Surgical History

| Year | Hospital – City, State | Type of Surgery/Procedure *Any complications, if any:* |
|---|---|---|
| | | |
| | | |
| | | |

## Family History

| Relation: | Age if living | Age @ Death | Medical Conditions: | Any History of: *Please check boxes that apply* |
|---|---|---|---|---|
| Father | | | | ☐ Cancer ☐ Stroke ☐ High BP ☐ Psych |
| Mother | | | | ☐ Cancer ☐ Stroke ☐ High BP ☐ Psych |
| Brother(s) | | | | ☐ Cancer ☐ Stroke ☐ High BP ☐ Psych |
| | | | | |
| Sister(s): | | | | ☐ Cancer ☐ Stroke ☐ High BP ☐ Psych |
| | | | | |

## Additional information *What else should your doctor know about your health?*

## Review of Systems

Please mark the box with any persistent symptoms you have and in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List any other concerns below.

**General:**

- ☐ Unexplained weight loss/ gain
- ☐ Unexplained fatigue/ weakness
- ☐ Fall asleep during day when sitting
- ☐ Fever, chills
- ☐ No Problems

**Skin:**

- ☐ New or change in mole
- ☐ Rash/ itching
- ☐ No Problems

**Breast:**

- ☐ Breast lump/pain/nipple discharge
- ☐ No Problems

**Ears/Nose/Throat:**

- ☐ Nosebleeds, trouble breathing through nose
- ☐ Trouble swallowing
- ☐ Frequent sore throat, hoarseness
- ☐ Hearing loss/ ringing in ears
- ☐ No Problems

**Eyes:**

- ☐ Change in vision
- ☐ Eye Pain
- ☐ Eye itchiness/ redness
- ☐ No Problems

**Musculoskeletal:**

- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle/Joint pain: _____
- ☐ Bone Density
- ☐ Osteoporosis
- ☐ No Problems

**Cardiovascular:**

- ☐ Chest pain/ discomfort
- ☐ Palpitations (fast/irregular heartbeat)
- ☐ No Problems

**Respiratory:**

- ☐ Cough/Wheeze
- ☐ Loud snoring/ altered breathing
- ☐ Shortness of breath with exertion
- ☐ No Problems

**Gastrointestinal:**

- ☐ Heartburn/Reflux/Indigestion
- ☐ Blood or change in bowels
- ☐ Constipation
- ☐ Diarrhea
- ☐ No Problems

**Genitourinary:**

- ☐ Leaking urine
- ☐ Blood in urine
- ☐ Nighttime urination increased frequency
- ☐ Discharge of Penis or Vagina
- ☐ Concern with sexual function
- ☐ No Problems

**Endocrine:**

- ☐ Heat or cold sensitivity
- ☐ Excessive sweating
- ☐ No Problems

**Hematologic/Lymphatic**

- ☐ Swollen glands
- ☐ Easy bruising
- ☐ No Problems

**Neurological:**

- ☐ Headache
- ☐ Memory Loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness/ tingling
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ No Problems

**Allergic/ Immune:**

- ☐ Hay fever/ allergies
- ☐ Frequent
- ☐ No Problems

**Psychiatric:**

- ☐ Anxiety/ Stress/ Irritability
- ☐ Sleeping Problem
- ☐ Lack of Concentration
- ☐ No Problems

**Women's Health:**

- ☐ Pre-menstrual symptoms (bloating/cramps,irritability)
- ☐ Menstrual problem
- ☐ Heavy Flow
- ☐ Migraines
- ☐ Hot flashes / night sweats
- ☐ Menopause
- ☐ No Problems

## Privacy Policy

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The privacy rule was also created to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those who we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we may have indirect treatment relationships with you (such as laboratories, radiology and pathology) that only interact with physicians and not patients and we may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information (PHI), but this must be in writing. Under the law effective April 14, 2003, we have the right to refuse to treat you should you choose to refuse disclosure of your (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

**If you have any objections to this form, please ask to speak with our HIPAA compliance officer.**

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy policy.

Print Name: _____

Signature: _____ Date: _____

(If patient is under 18 years of age, a parent or guardian must sign). (This policy expires ten years from the original date signed).

## Consent for Teaching Practice

For over 30 years, Dr. Roger Washington has served as preceptor and teacher for Stanford Medical student graduates, physician assistants, family practice residents, and international medical graduates. This is a teaching practice focusing on educational advancement of future physicians and healthcare providers.

Patient examinations, diagnostic tests and/or medical treatment provided in person or over telemedicine may be used for advancing the technical proficiency of resident physicians, fellows, medial and nursing students who may be present during the visit or observing via telehealth.

They may also take part in discussions concerning the patient's medical condition(s), diagnostic tests, and treatment plan. No medical data will be recorded or transmitted without the patient's consent. We remain HIPAA compliant and respect our patient's wishes and will confirm with authorization before each visit.

☐ I hereby authorize to participate in the teaching practice.

☐ I do not consent to participate in the teaching practice.

_____ _____ Date: _____

Printed Name Signature

# Authorization for Use/Disclosure of Health Information

I _____ voluntarily consent to authorize my health care provider:
*Print Name*

Dr. Roger W. Washington To use or disclose my health information during the term of this authorization to the recipient(s) that I have identified below.

**Recipient:** I authorize my healthcare information to be released to my primary care physician:

Name: Dr. Roger W. Washington MD, FAAFP
Address: Roger W. Washington, MD, Inc.
2365 Quimby Rd. Ste.260
San Jose, CA 95122

Phone: (408) 246-9926
Fax: (408) 246-7877
Email: DrW@FPClinic.com
NPI: 1295812816

I authorize the release of all my health information that the provider has in their possession. Including and not limited to: information relating to any medical history, mental or physical condition and any treatment that I may have received. Including diagnostic results, radiology reports, vaccination records, and dispensed medications at my request as a patient.

**NOTE: This authorization does not extend to HIB test results, outpatient psychotherapy notes, drug or alcohol treatment records. Due to protection of federal law, or mental health records that are protected by the Lanterman Petris-Short Act.**

I understand that this authorization will remain in effect until the provider fulfills this request and records have been received by Dr. Roger Washington.

I understand that my healthcare provider cannot guarantee that the recipient will not disclose my health information to a third party.
The third party may not be: _____

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Patient contact information: _____