

Patient Information

Last name:	First name:	MI:	
Date of birth:	<input type="radio"/> Male <input type="radio"/> Female		
Home address:	City:	State:	ZIP:
Mailing address: <input type="checkbox"/> <i>Same as home.</i>	City:	State:	ZIP:
Phone #1: () <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell	Phone #2: ()	<input type="radio"/> Home	<input type="radio"/> Work <input type="radio"/> Cell
Email address:			
Emergency contact:	Phone: ()	Relationship:	
Preferred clinic: <input type="radio"/> Downtown Seattle <input type="radio"/> Kent Station <input type="radio"/> Mercer Island		Preferred clinician: <i>(if known)</i>	

Dependent Information

Last name:	First name:	MI:	
Relationship to employee:	Date of birth:	<input type="radio"/> Male	<input type="radio"/> Female

Last name:	First name:	MI:	
Relationship to employee:	Date of birth:	<input type="radio"/> Male	<input type="radio"/> Female

Last name:	First name:	MI:	
Relationship to employee:	Date of birth:	<input type="radio"/> Male	<input type="radio"/> Female
Does a dependent have a different mailing address? <input type="radio"/> No <input type="radio"/> Yes, please complete the following:			
Dependent's name:	Mailing address:		

Billing Preference

Billing Frequency:	<input type="radio"/> Annually	<input type="radio"/> Semi-Annually	<input type="radio"/> Quarterly	<input type="radio"/> Monthly	<input type="radio"/> Ancillary Only
OPTION A: Credit Card or Debit Card					
Name on card:	Card type: <input type="radio"/> Visa <input type="radio"/> MasterCard <input type="radio"/> American Express				
Card number:	Expiration date:				
Card billing address: <input type="checkbox"/> <i>Same as home.</i>					
<input type="checkbox"/> Yes, please add me to the billing account of: _____, existing Qliance patient & associated with the above account.					
OPTION B: Automatic Funds Transfer					
Name on account:	Account type: <input type="radio"/> Checking <input type="radio"/> Savings				
Bank name:					
Account number:	Routing number: <i>(Please attach a voided check to this form.)</i>				
<ul style="list-style-type: none"> By signing below, I understand that my participation in Qliance is continuous & I hereby authorize Qliance to initiate charges to my credit card, debit card or bank account for my periodic membership fee & 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 & effect until Qliance has received written notification from me of its termination in such time & in such manner as to afford Qliance & my financial institution a reasonable opportunity to act on it. I understand that a \$25 fee will be charged to the entity named above, myself or my employer for declined credit, debit card or automatic funds transfer transactions that are not honored. 					
ACCOUNT HOLDER SIGNATURE:					DATE:
PRINT NAME:			SIGNATURE BY: <input type="radio"/> Patient <input type="radio"/> Parent <input type="radio"/> Legal Guardian		

OFFICE USE ONLY				Date
Patient No. :	Billing No. :	QDating Duration: / / - / /		

Terms

Patient Agreement & Disclosure Statement

- By signing below, I hereby authorize Qliance to contact me using the information I have provided above.
- 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* available online at www.Qliance.com 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/specialist/lab services and that Qliance will not bill insurance carriers for any services provided by Qliance. I also understand that I may submit changes to my health insurance.
- I acknowledge and understand that Qliance must maintain the privacy of my health information as per the terms of Qliance's *Patient Privacy Policy*. 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 understand that I may terminate this *Patient Agreement* at any time and for any or for no reason by providing written notice to my Human Resources Department or directly to Qliance. The *Qliance Service Cancellation Form* can be found at www.Qliance.com.
- I acknowledge and understand that Qliance may terminate this *Patient Agreement* by providing me written notice. 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 ancillary items at any time.
- 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 and Responsibilities

- I understand that I have the right to choose my personal health care provider and to change my provider at any time, for any reason. I understand that all reasonable efforts will be made to accommodate my request, but only if my new provider'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 provider, 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.
- I understand that I have the right to considerate, respectful, and nondiscriminatory care from my Qliance health care provider(s). I also understand that I am responsible for communicating clearly and respectfully with my provider.
- 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 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.
- I understand that I have the right to a fair, fast and objective review of any complaint I have against my health care provider(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. 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. 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.
- I understand that I am responsible for being actively involved in my health care decisions and to disclose all relevant information to my Qliance health care provider(s) so that they can help me achieve my health goals. I understand that I am to inform my Qliance health care provider(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 provider(s) about protecting the health and safety of myself and others.

By signing 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: Patient Parent Legal Guardian

NAME:	DOB: <i>mm/dd/yyyy</i>	DATE:
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HEALTH ASSESSMENT
What is most important to you about your medical care? <i>(e.g. communication, prevention, wellness planning)</i>
What specific concerns would you like to address with your new clinician?

MEDICATIONS & ALLERGIES				
Please list all your current medications and allergies <i>(including vitamins & supplements)</i> .				
Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
4.				
5.				
Allergies to medication and other items:				
1.			Reaction:	
2.			Reaction:	
Preferred pharmacy:		Phone:	Fax:	
Address:				

PERSONAL MEDICAL HISTORY			
Have you ever had any problems with the following: <i>(If yes, please explain.)</i>			
<input type="checkbox"/> Alcohol or substance abuse:		<input type="checkbox"/> Metabolism <i>(diabetes, thyroid etc.)</i>	
<input type="checkbox"/> Blood:		<input type="checkbox"/> Muscle, joint, bones:	
<input type="checkbox"/> Cancer:		<input type="checkbox"/> Nerves and brain:	
<input type="checkbox"/> Digestion:		<input type="checkbox"/> Skin and hair:	
<input type="checkbox"/> Ear, nose, throat, eyes:		<input type="checkbox"/> Sleep:	
<input type="checkbox"/> ER Visits:	Type:	Date:	<input type="checkbox"/> Social, mental or emotional health:
<input type="checkbox"/> Heart or blood vessels:		<input type="checkbox"/> Surgeries:	Type: Date:
<input type="checkbox"/> Hospitalizations:	Type:	Date:	<input type="checkbox"/> Women's health:
<input type="checkbox"/> Kidneys or bladder:		Pregnancies (#):	Births (#): Living Children (#):
<input type="checkbox"/> Lungs:		Other:	
<input type="checkbox"/> Men's health:			

FAMILY MEDICAL HISTORY		
Please indicate any family members who have had the following:		
<input type="checkbox"/> Alcohol abuse:	<input type="checkbox"/> Bleeding disorders:	<input type="checkbox"/> Deafness:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Breast cancer:	<input type="checkbox"/> Dementia:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Cancer of an unknown type:	<input type="checkbox"/> Depression:
<input type="checkbox"/> Autism:	<input type="checkbox"/> Colon cancer:	<input type="checkbox"/> Diabetes:

Continued on page 2

NAME:	DOB:
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Family Medical History Continued

<input type="checkbox"/> Bipolar disorder:	<input type="checkbox"/> Cystic fibrosis:	<input type="checkbox"/> Glaucoma:
<input type="checkbox"/> Heart attack:	<input type="checkbox"/> Lymphoma/Leukemia:	<input type="checkbox"/> Schizophrenia:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Osteoporosis:	<input type="checkbox"/> Sickle cell anemia:
<input type="checkbox"/> High blood pressure:	<input type="checkbox"/> Ovarian cancer:	<input type="checkbox"/> Skin cancer:
<input type="checkbox"/> High blood cholesterol:	<input type="checkbox"/> Obesity:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> HIV:	<input type="checkbox"/> Parkinson's disease:	<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Inherited anemias (<i>i.e. thalassemia</i>):	<input type="checkbox"/> Prostate cancer:	<input type="checkbox"/> Thyroid:
<input type="checkbox"/> Inflammatory bowel disease (<i>e.g. Crohn's disease</i>):		<input type="checkbox"/> Other cancer:
<input type="checkbox"/> Any other condition that two or more relatives have?		

SOCIAL HISTORY & LIFESTYLE				
Relationship status: <input type="radio"/> Married or Partnered <input type="radio"/> Single <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed				
What is your highest level of education?		Occupation:		
Do you have any children? <input type="radio"/> Yes <input type="radio"/> No				
Name:	DOB:	Lives at home?	<input type="radio"/> Yes	<input type="radio"/> No
Name:	DOB:	Lives at home?	<input type="radio"/> Yes	<input type="radio"/> No
Who also lives at home with you?				
Do you have any pets? <input type="radio"/> Yes <input type="radio"/> No				
Have you ever been neglected or abused, physically, emotionally or sexually?				
If yes, are you currently living in an unsafe situation? <input type="radio"/> Yes <input type="radio"/> No				
Do you have more than one sexual partner? <input type="radio"/> Yes <input type="radio"/> No				
Sexual Partners: <input type="radio"/> Men <input type="radio"/> Women <input type="radio"/> Both <input type="radio"/> None				
Do you practice safer sex? (<i>i.e. use condoms</i>) <input type="radio"/> Yes <input type="radio"/> No				
What are you using for birth control?				
On average, how many alcoholic drinks do you consume per week?				
In the past year, how many times have you had more than 4 (females), 5 (males) drinks in one day?				
Do you use or have you ever used tobacco products?				
Does anyone smoke around you?				
Do you use or have you ever used recreational drugs? <input type="radio"/> Yes <input type="radio"/> No				
How much caffeine do you consume daily? (<i>coffee, soda, chocolate etc.</i>)				
Do you have concerns about your diet? <input type="radio"/> Yes <input type="radio"/> No				
What do you do for exercise?				
Do you have: <input type="radio"/> A living will <input type="radio"/> Power of attorney <input type="radio"/> Durable power of attorney for health care				

HEALTH MAINTENANCE & PREVENTION			
When was the last time you:			
Visited the dentist:		Had a Tetanus booster:	
Had a blood sugar test:		Had a cholesterol test:	
Had a colon cancer screening:			
Type:	<input type="radio"/> Colonoscopy	<input type="radio"/> Flexible sigmoidoscopy	<input type="radio"/> Occult blood stool test (<i>card</i>)
Women's Health			
When was your last:	PAP smear?	Mammogram?	Bone density test?
Men's Health			
When was your last:	Prostate exam?		

This section describes the care you 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)

I have been able to get care from my primary care clinician when and how I need it.	
I have had a personal health care provider (doctor, nurse practitioner etc.) who knows me as a person.	
The bulk of my health care needs have been met by my primary care provider's office.	
My primary care clinician has coordinated my care throughout the health care system.	
When I have visited my primary care provider's office, it has been organized and efficient.	

PATIENT SELF HEALTH ASSESSMENT

How do you rate your health? Poor Fair Good Very Good Excellent

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

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

During the past 4 weeks, how much work have you missed due to physical or emotional problems?

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

During the past 4 weeks, has your physical or emotional health limited your social activities?

Yes No

In the past 3 months have you had any injury or illness that has kept you in bed for all or most of the day?

Yes No

In the past year, have you gone to the ER for care?

Yes No

In the past year, have you stayed in the hospital overnight or longer?

Yes No