

Eastside Women's Health & Lactation

Registration Form

Name:		Today's Date:	
Birth Date:		Baby's Birth Date:	
Street Address:		City, State, Zip:	
Cell Phone:	Home:	Work:	
Occupation:		Employer:	
Email:		Subscribe to e-newsletter? Yes No	
How did you hear about EWHL?			
INSURANCE INFORMATION Please give your insurance card and photo ID to the receptionist.			
Primary Insurance:			
Insurance ID #:		Group #:	
Co-Pay: \$			
Subscriber's Name		Subscriber's Birth Date:	
Subscriber's SS #:		Relationship to Subscriber:	
Secondary Insurance:		Subscriber Name:	
Group #:		Policy #:	
Baby's Insurance (if different from Mom):		Subscriber Name & SSN:	
Group #:		Policy #:	
IN CASE OF EMERGENCY			
Name:		Relationship:	
Cell Phone:		Work Phone:	
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION			
May we call you at home? Yes No		May we leave a message at your home? Yes No	
May we leave a message on your cell? Yes No		May we call you at work? Yes No	
I acknowledge & agree to adhere to the Notice of Privacy Practices as required by federal & state guidelines. I understand I may request/review a copy of these Practices at any time from the office staff. I permit the release of any information, including my medical records that may be requested by my insurance company to process any claims.			
Patient/Guardian Signature:		Date:	
CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION			
I have completed this form and certify that I am the patient or legal guardian of patient. I authorize the providers of Eastside Women's Health & Lactation (EWHL) to provide medical care and treatment for me. I authorize payments of benefits to be made directly to EWHL. I understand that as the recipient of services, regardless of insurance coverage, that I am ultimately responsible for payment within 30 days of the date of service or statement and billing fees may be assessed. Failure to pay in 30 days could result in a \$10 late fee.			
Patient/Guardian Signature:		Date:	

Mother's Name:	Baby's Name:
Age:	Birth Date:
	Today's Age:

Allergies for Mom:

Allergies for Baby:

Reason for Today's Visit:

Have you seen anyone else for this issue?

Mom's midwife/OB:

Baby's Pediatrician:

Personal/Family: Please check if you/family have or have had the following.

Ages of other children and duration of BF:

Who in your family has BF?

Breast surgery Abuse Depression
 Allergies Alcohol Smoke
 Recent illness/hospital other than birth Dairy Caffeine
 Eating disorder Special Diet

Labor & Birth History

Pregnancy Planned: Yes No

Fertility Problems? Yes No If yes, what treatments did you do?

Breast changes in pregnancy Yes No Do you get frequent yeast infections? Yes No

High B/P Wt gain: Labor at _____ weeks
 Labor induced Bag of waters broken by provider Epidural
 Other meds in labor Quality/length of labor:

Birth: Vaginal Vacuum Forceps Cesarean

Feelings about labor & birth:

Baby History

Appgars: Birth Weight: When did 1st nursing occur?

Separation Supplements Pacifier Jaundice
 Milk In Engorged Nipple Pain Circumcised

<input type="checkbox"/> Baby sick	<input type="checkbox"/> Pumped	<input type="checkbox"/> Alternate feedings
Baby's overall mood:		
Current Breastfeeding Pattern		
<input type="checkbox"/> Exclusive BF	# BF/day:	Avg length:
Who ends BF:	Time between:	
Longest sleep:		
How much pumped out:		
How much supplement:	<input type="checkbox"/> Mom's milk:	<input type="checkbox"/> Formula:
How are you giving supplement?		
#of wet diapers/24hours:		#of poop diapers/24 hours:
Is baby <input type="checkbox"/> fussy	<input type="checkbox"/> calm	<input type="checkbox"/> sleepy
<input type="checkbox"/> other	<input type="checkbox"/> pacifier	
Medications for Mom or baby:		
Mom's overall mood:		
Mom's breastfeeding goals:		
Because it is so common and we are concerned about your safety, we ask all patients about the presence of violence in their home and relationships. We want you to be safe, and we can help. Are you being:		
<input type="checkbox"/> Hurt	<input type="checkbox"/> Threatened with physical harm	
<input type="checkbox"/> Insulted or talked down to	<input type="checkbox"/> I have a history of sexual/physical abuse.	
<input type="checkbox"/> Screamed at or cursed		
To the best of my knowledge, the questions on this form have been answered correctly.		
Patient Signature		
I have read and reviewed the information provided by the patient/guardian above.		
Kristina Chamberlain, CNM, ARNP, IBCLC		



Financial Contract & Office Policies

As a patient of the Eastside Women's Health & Lactation, and by signing below, I agree to the financial responsibilities for any fees not covered by my insurance carrier and to the office policies listed below. Any outstanding fees must be paid at time of service. I also understand that it is my responsibility to confirm insurance coverage before my scheduled appointment.

Fees, Third Party Billing & Co-pay Policy: In addition to the policy stated above, inability to pay your co-pay at the time of service will incur a \$10 service charge. If you have any questions regarding your insurance coverage or fees, you can contact your insurance directly, or contact Alternative Medical Billing Service, LLC at (206) 932-0870. If you are self pay, you may contact the office for a fee schedule.

Insufficient Funds Policy: If a check does not clear due to insufficient funds, a \$25 fee will be added to the outstanding balance.

Late Policy: EWHL respects your time, and we ask that you respect ours. Appointments are not double-booked and do not intentionally run over. If you are more than 10 minutes late for your appointment, you may be seen for any time remaining or asked to reschedule. If you expect to be late, please let Kristina Chamberlain know as soon as possible by calling the office at 425-814-2045.

No Shows/Cancellations Policy: If you need to cancel an appointment, please do so within 24-48 business hours of the appointment time. Business hours do not include weekend or holidays. Appointments cancelled with less than 24 hours notice will incur a \$30 fee for a follow-up appointment and \$50 for an initial appointment. Three unexplained no-shows will result in dismissal from the practice.

Phone & Email Consults: Brief questions can be answered over the phone or email at no charge. Complex concerns will not be answered this way; it is not good practice and can result in less optimal care. If you have a more complex concern, you will be asked to make an appointment, or you will be charged \$50 for a more involved phone/email consult.

Name of Patient (Print)

Signature of Patient

Today's Date



EWHL's Consent for Treatment and Acknowledgement of Receipt of Notice of Health Information Privacy Practices and Consent to Disclosures

Name of Patient: _____ Today's Date: _____

Date of Birth: _____ Phone: _____

As a patient of the Eastside Women's Health & Lactation and by signing below:

I hereby authorize Kristina Chamberlain, CNM, ARNP, IBCLC to provide care, perform general diagnostic procedures and exams as necessary to facilitate my diagnosis and treatment.

I understand that I may ask questions regarding my diagnosis, treatment, fees, and insurance coverage, or any other aspect of my care before signing this form. With this knowledge, I voluntarily consent to the policies and procedures of Eastside Women's Health & Lactation.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during visits. I understand that free interpretive services may not be available and that I may be referred to another health care facility to provide the services necessary for my care.

No guarantee has been or will be given to me as to the results that may be obtained from any services I receive. I know that it is my choice to obtain these services and that I may change my mind about receiving medical care from Eastside Women's Health Services at any time.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive test results to the public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if a referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by a representative or me, or otherwise permitted or required by law.

I understand that I have the right to review my record and obtain a copy of my record upon request (see *Notice of Privacy Practices*) and that obtaining a copy of my record may require payment of a fee.

I hereby certify that I have reviewed the *Notice of Privacy Practices* for Kristina Chamberlain, CNM, ARNP, IBCLC/Eastside Women's Health & Lactation that is available on the website. I understand that if I have objections or concerns with this policy, I must notify Kristina Chamberlain, CNM, ARNP, IBCLC.

_____ Today's Date _____

Patient Name (printed)

Signature by Patient/Parent/Guardian

