Douwe Rienstra, MD

Rienstra Clinic
708 Kearney Street
Port Townsend, WA 98368-5709

www.RienstraClinic.com

Integrative Health Systems, P.S.

PLEASE PRINT

PATIENT_____ **BIRTHDATE**_____ M☐ F☐
First name Middle Last

For positive identification and linkage of your medical records to you and you only, please provide
Drivers license number _____ Last 4 digits of your social security number _____

Please address me by my ☐ first name ☐ last name Spouse or Domestic Partner _____

If minor, name of parent or legal guardian _____

MAILING ADDRESS_____

_____
City State Zip

Email address _____@_____ **for our popular monthly newsletter**

PHONE: Home _____ Work _____ Cell _____

Message _____ IF FROM OUT-OF-TOWN, please give a local phone no _____

Personal and secure **FAX** number for lab results and medical reports:_____

EMPLOYER_____OCCUPATION_____

How did you hear about us?_____

If a person---name, address and/or phone number_____

Emergency Information
NAME OF RELATIVE, FRIEND OR NEIGHBOR TO CONTACT IN EMERGENCY. PLEASE DO NOT LIST ANYONE LIVING AT THE SAME ADDRESS AS YOURSELF.

NAME_____ PHONE_____

ADDRESS_____
Number & Street City State Zip

RELATIONSHIP TO PATIENT:_____

WE ARE REQUIRED BY LAW TO INCLUDE THESE QUESTIONS:
You are not required to answer

Do you have a living will?_____durable power of attorney for health care? _____

If not, do you wish additional information?____yes____no

The existence or execution of a living will, durable power of attorney for health care, or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate against an individual.

SIGNATURE_____DATE_____

PLEASE COMPLETE OTHER SIDE

Medical Privacy. We make every effort to keep your medical information private. If you ask us to send your records to anyone, we will inform them that your records are protected health information, but cannot be responsible beyond that point.

We may discuss your health care with other providers involved in your care such as physicians, pharmacists, laboratories, radiology facilities, physical therapists and other professionals, solely to improve the care you receive.

We are required to disclose information without your permission in the case of a legally sanctioned subpoena, requirements of Child and Adult Protection laws, or for certain communicable diseases.

Financial and Liability Agreement

With the exception of Washington State Labor & Industries care, I will pay for all services at the time of service.

I have had adequate time to review this agreement and the medical privacy statement. I do not rely on any representations by Dr Rienstra or anyone in his office in connection with this agreement. I have not been coerced or pressured to sign this agreement in any way, and I do not currently have an emergency medical problem.

_____	_____	_____	_____
Signature	Date	Witness	Date

Reports to other physicians.

O My primary care provider is Dr:

O Address:

Cost control. Sometimes we are faced by problems that are more complex than anticipated. Sometimes people think of other problems during the visit. Ordinarily these have to be postponed to a later date.

O If clinic schedule allows, please take the extra time today to avoid a return visit, even if cost is higher than quoted.

O Please just address the problems I came in for.

Additional Services. We provide telephone service, email service, prescription refills, and additional services at our usual rates. **Please keep photocopies of your prescriptions until they expire to avoid unnecessary prescription refill fees.**

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