Larry D. Stonesifer, M.D., F.A.C.P., F.A.C.E.

Internal Medicine/ Endocrinology & Metabolism

St. Francis Medical Building B

34509 9th Ave South Suite 200 Federal Way, WA 98003

Phone: (253) 927-4777 Fax: (253) 927-6580

Welcome to the office of

Larry D. Stonesifer, M.D.,
Marcia K. Miller, A.R.N.P.,
Marjorie J. Sladek, A.R.N.P.

- Please take a moment to fill out our registration packet and review our office policy, sign each page, and use the self-addressed stamped envelope to mail **all** the page's back to us
- Please be sure to have **any records** pertaining to your consultation visit faxed or mailed to our office to further assist in your care prior to your appointment. If you have My Chart or copies of your records, feel free to bring them with you to your appointment.
- Please bring your insurance card and photo ID with you to this, **and every subsequent appointment.**
- Please bring a **complete list** of all your medications and how they are taken, or bring the actual containers; we also ask all **diabetic patients to bring your meters with you.**
- If your insurance requires a **referral,** please be sure to obtain that from your **primary care provider** prior to your appointment.
- As a courtesy, you will be called (2) two days in advance to remind you of your upcoming appointment.
- Any new patient appointment not cancelled at least 48 hours prior to the date and time of appointment, may be charged a missed appointment fee that will not be billed to your insurance.
- **All co-pays are due at time of service.** We accept cash, personal check, and all major credit card/debit cards.

We look forward to meeting you and appreciate the opportunity to assist in your care!

LARRY D. STONESIFER, M.D., F.A.C.P., F.A.C.E.
MARCIA K. MILLER, A.R.N.P.
MARJORIE J. SLADEK, A.R.N.P.
Internal Medicine/Endocrinology & Metabolism
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Today's Date: ______________________

PLEASE PRINT

Patient Information

Name ____
First M/I Last

D.O.B ________________ Male ___ Female ___ Social Security Number(optional) ______________________

Address ____
Street City State Zip

Primary Contact Phone ________________________ Additional Number(optional): _______________________

Employed? ___Yes ____ No

Employer Name _______________________ Occupation ______________________________

Employer Address ____

Spouse/ Parent Name ____
First M/I Last

Address (If not the same): ____
Street City State Zip

Primary Contact Phone _________________________ Employed: ___Yes ____ No

Employer Name _________________________________ Occupation ________________________________

REFFERING PHYSCIAN: ____

Phone: ( ) _____________________________ Fax: ( ) _____________________________

EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency that is not at the same address

Name: ______________________ Phone:_________________ Relationship to patient __________________

AUTHORIZATION FOR TREATMENT OF A MINOR (18 or younger)

Signature of parent or legal guardian ____ Date:____________

Patients Name ____
First M/I Last

PRIMARY INSURANCE

INSURANCE COMPANY NAME: ____

POLICY/ID NUMBER: __________________________________ GROUP NUMBER __________________________________

SUBSCRIBERS NAME: ____________________________ DOB ______________ Employer: ___________________________

Subscribers Relationship to patient: ( ) Self ( ) Spouse ( ) Parent ( ) Guardian ( ) other

SECONDARY INSURANCE:

INSURANCE COMPANY NAME: ____

POLICY/ID NUMBER: ___________________________________ GROUP NUMBER __________________________________

SUBSCRIBERS NAME: ____________________________ DOB _______________ Employer: ___________________________

Subscribers Relationship to patient: ( ) Self ( ) Spouse ( ) Parent ( ) Guardian ( ) other

TO OUR VALUED PATIENTS:

The following information on co-insurance will help you understand our billing policies. We bill all county medical bureaus. If you have co-pay we ask that you pay at the time of service (Please have the correct change if paying in cash). We bill Medicare and accept assignment. If you have a secondary insurance that picks up the balance, please list it. We also bill and accept assignment from welfare (Medical Coupons) and we must have a current copy at the time of the visit.

LIFETIME AUTHORIZATION:

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim. This form is used in lieu of the patient's signature on form HCFA 1500 and is therefore an extension of that form.

Signature: ____________________________________ Date: ____________________

Patients Name: ____

First M/I Last

Reason for being seen:____

List Ongoing Medical and Psychological problems	Year	Surgeries, Hospitalizations, Broken Bones	Year

Personal History:

Occupation: ______________________ Married ___ Single ___ Divorced ___ Widowed ___ Domestic Partner ___

Do you have children? Y N How Many? _____________

Do You Exercise? Y N Type? ___________ How Often? ___________

Over the last 5 years what was your: Highest weight? _______ Lowest Weight? _______ Goal Weight? ________

Tobacco use? Y N How much per day? _________ Age started _____ Age Quit? _____

Ever Drink Alcohol? Y N Drinks per week? __________ Ever want to Cut Down? Y N

Any Use of Illegal Drugs/ Street Drugs? Y N

Do you feel safe at home? Y N Ever experience physical/ verbal violence or abuse? Y N

Family History (Biological)	Father	Mother	Grand-Parents	Siblings
Heart disease/ Heart attack				
High blood pressure				
High cholesterol				
Stroke				
Diabetes				
Seizures				
Glaucoma/Retinopathy				
Alcohol/Drug addiction/ Mental illness				
Thyroid problems				
Osteoporosis				
Cancer(s): Breast				
Colon				
Ovarian				
Other				

Allergies: Y N
(If yes, Please List):

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________

Medication(s): Please include non-prescription drugs, vitamins & "natural" treatments.

Medication name	Strength	Medication name	Strength
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Patients Name: ____
First M/I Last

If you have Diabetes please fill out the following:

Do you check your blood sugar levels? Y N If yes, how often? _______________

Usual Results? ________________

Results of last A1c? _____________ Date Taken? ________/_______/_______

Do you have a special meal plan? Y N If yes, what type? __________________

Please list typical food intake Time up? ________ Time to bed? ________

Breakfast/ Time	Snack/ Time	Lunch/ Time	Snack/ Time	Dinner/ Time	Bed/ Time

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OFFICE POLICY

Due to the substantial increase in NO-SHOW appointments and a long wait list for appointments, it has become necessary for us to activate the following list of office policies. We appreciate your cooperation and will try to accommodate you in a timely manner.

Any new patient appointments not canceled 48 hours prior to the date and time of the service may have a missed consultation appointment charged to the patient that will not be billed to their insurance.

Any follow up appointment not canceled 24 hours prior to the date and time of service may have a missed appointment charged to the patient that will not be billed to their insurance.

Co-payments are due at the time of service. If co-payments have to be billed there may be an additional $10.00 processing fee that will be charged to the patient. We accept payment by cash, personal check, visa and master card. *(All returned checks will be charged a $35 service charge).* Unpaid balances beyond 60 days due will begin accruing an additional **$3.00** administrative fee per month until paid in full.

Prescription refill requests should be directed to your pharmacy as 'refill requests'. Your pharmacy will notify us either electronically or by fax. Please allow up to 48 hours from the time your pharmacy notifies us to fill your prescriptions. We make every effort to fill all refill requests received by 4:30 p.m. same business day. However, NO REFILLS WILL BE DONE ON WEEKENDS, OR HOLIDAYS.

At this time, we are **only** set up to bill secondary insurance for patients **with** Medicare coverage. Please be aware that all **NON-MEDICARE PATIENTS** must send the bill to their secondary insurance carrier. If you have a secondary insurance, but it is not Medicare, and your primary insurance carrier has designated an office visit co-pay, it will be due and time of service.

Due to the large volume of phone calls, it is no longer possible for us to call patients to report normal laboratory or other test results. Please be assured that if there are any significant abnormalities in your lab or changes to be made prior to your next visit we will notify you promptly.

Patients that have Managed Care Insurance (HMO) will be responsible to obtain all necessary referrals, records, and authorizations from their primary care doctors and have them available for the chart prior to their appointment. We will do our best to remind you when they are needed but the basic responsibility will be with the patient and their primary care provider. If the claim is denied due to lack of referral, the patient agrees to be directly billed for all charges.

At this practice, we are committed to treating and using protected health information about you responsibly. We have clearly posted in the office waiting room a copy of our
detailed notice of PATIENT PRIVACY PRACTICES. A copy of this notice is available upon request if you wish to have a copy for your personal records. Please ask for your copy now or at any visit and we will be pleased to provide one for your review. We encourage you to check this notice at each visit for any revisions.

I wish to be contacted in the following manner (*check all that apply*):

Home Telephone ____ Written communication ____

_____ Leave message with detailed information _______ Mail to home address

_____ Leave message with call back number only _______ Fax to this number

I hereby give permission for Larry D. Stonesifer, M.D., Marcia K. Miller ARNP, and Marjorie Sladek, ARNP to disclose information regarding my treatment to:

(Please list them by name)

___ Spouse ____ Son/Daughter ___ Other Relative

____________________________ ____________________________

____________________________ ____________________________

By my signature below I acknowledge that I have read and understand the policies and disclosures of this practice.

____
Print patient or legal authorized individual name

____
Patient or legal authorized individual signature

__________/___________/__________
Date