



PATIENT INFORMATION

Patients last name:		First:	MI:
Street Address:		PO Box:	Birth date: / /
City:	State:	Zip Code:	Marital status: Sex: Male or Female
Social Security:		1st phone:	2nd phone:
Email address:		Would you like electronic access to your chart? Y / N	
May we leave a message for appointments or Normal lab values: Y / N		If yes, primary number:	
Primary Care Physician:		City:	State:
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Decline			
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Decline		Preferred Language:	Organ Donor: Y / N
Do you have an Advanced directive? <input type="checkbox"/> Yes, it's located:			<input type="checkbox"/> No
Do you have a Living Will? <input type="checkbox"/> Yes, it's located:			<input type="checkbox"/> No
Do you have a Medical Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No		POA name:	Phone:

INSURANCE/GUARANTOR INFORMATION

Person Responsible for bill:			
Address(if different):		PO Box:	Birth date: / /
City:	State:	Zip Code:	Marital status: Sex: Male or Female
Employer:		Employer address:	
Is this an injury that occurred at work? <input type="checkbox"/> No <input type="checkbox"/> Yes- if so, date of injury?			Claim#:
Name of Primary Insurance:		Subscriber's name:	
Group#:	Subscriber ID#:	Relation to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Address:		SSN:	Birth date: / /
Name of Secondary Insurance:		Subscriber's name:	
Group#:	Subscriber ID#:	Relation to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Address:		SSN:	Birth date: / /

IN CASE OF EMERGENCY

Primary Contact:		Phone:
Address:	City: State:	Relationship to patient:
Secondary Contact:		Phone:
Address:	City: State:	Relationship to patient:

MEDICARE PATIENTS ONLY

Are you receiving benefits from any of the following programs: Black Lung: Y / N Veteran Affairs: Y / N Disability: Y / N		
Government research: Y / N If Yes, date benefits began:		
Kidney Dialysis or Transplant: Y / N ESRD Y / N If yes, date benefits began:		
Are you employed: Y / N	Spouse: Y / N	Date of retirement Self: Spouse:
Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? Self or Spouse		
Does the employer that sponsors your GHP employ 20 or more employees? Y / N		



Snoqualmie Valley Hospital
Consent for Treatment/Notice of Privacy Practices/Patient Rights & Responsibilities

AUTHORIZATION AND CONSENT FOR TREATMENT

I authorize Snoqualmie Valley Hospital and its designated representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

Notice of Privacy Practices: This Notice of Privacy Practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Rights and Responsibilities: This brochure outlines your patient rights including your rights to be informed of medical decisions, to participate in the development and implementation of your plan of care, to privacy during your care as well as to receive care in a safe setting.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

I hereby acknowledge receipt of the Notice of Privacy Practices (Initials) and Patient Rights and Responsibilities (Initials)

ASSIGNMENT OF INSURANCE BENEFITS AND CLINIC/HOSPITAL FINANCIAL AGREEMENTS:

Assignment of Insurance Benefits: I authorize my insurance benefits to be paid directly to the provider of services. If my insurance company determines that a particular service is not covered reasonable or necessary, I agree to be personally responsible for this account.

Clinic Self-Pay Financial Agreement: I am currently not covered by an insurance plan and will be personally responsible for payment of services to me at Snoqualmie Valley Hospital Clinics. I am expected to pay in full at time of service. I will receive a 30% discount at time of up-front payment.

Hospital Self-Pay Financial Agreement: I am currently not covered by an insurance plan and will be personally responsible for payment of services provided to me at Snoqualmie Valley Hospital. I understand that I may request a payment plan or financial aid assistance if I meet the qualifications.

Please note that additional charges may accrue after your initial visit, such as lab charges.

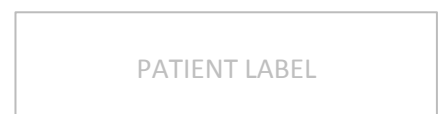
For more information on understanding your bill, setting up a payment plan, financial aid, or applying for Medicaid, please contact the Snoqualmie Valley Hospital Billing Office at (425) 831-2310.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT.

Patient or Authorized Representative: Date:

Printed name if signed on behalf of patient: Relationship:

Witness:



Pediatric Health History

(Birth - 18 Years Old)

Name: _____ Date: _____ Age: _____

Birthdate: _____ Parent(s) Name: _____

Sibling(s) Names: _____

Medical History *(Circle Y for Yes and N for No)*

Y N Was pregnancy/birth of this child complicated in any way?
If yes, please describe: _____

Y N Has your child been to the emergency room or urgent care facility in the past year?
If yes, please describe: _____

Y N Does your child have any chronic medical problems?
If yes, please describe: _____

Y N Has your child been seen in the last year for their chronic medical condition(s)?
If yes, please describe: _____

Medications *(Specify daily or periodic use)*

Environmental/Seasonal Allergies *(list reaction)*

Medication Allergies *(include reaction)*

Surgical History *(include date and reason)*

Gynecologic History *(girls only)*

Has first period occurred? Y N

If yes, at what age? _____

Date of last menstrual period: _____

Current birth control method: _____

Immunization Status *(check and write last date)*

We will survey state registry for you.

Last Tetanus *(with Pertussis Tdap)* _____

Gardasil/HPV Vaccine _____

Flu Shot _____

Name: _____

Social History

Diet Type: Regular Vegetarian/Vegan Restricted

Which do you routinely use: Helmet Seat Belts Sun Screen Safety Glasses

Circle Yes (Y) or No (N) <answer if you are 13 or older>

Y N Any concerns about behavior?

Y N Any concerns about school performance?

Y N Do you drink caffeine? If yes, how many drinks per day: _____

Y N Do you use cigarettes/chewing tobacco? If yes, how many packs/other per day: _____

Y N Do you exercise regularly? If yes, how often per week: _____

Y N Do you feel safe in your personal relationships?

Current Symptoms (check all that apply to you in the last 3 months)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Recent Weight Change | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Memory Loss or Confusion | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Spitting up Blood | <input type="checkbox"/> Depression | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Heat or Cold Intolerance | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Burning with Urination | <input type="checkbox"/> Excessive Thirst or Urination | <input type="checkbox"/> Regurgitation |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Bleeding or Bruising Tendency | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Swallowing Difficulty | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Recent Change in Bowel Habits |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Headaches | | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Seizures | | <input type="checkbox"/> Black, Tarry Stools |
| <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Numbness | | |

Family History

Has anyone in your family had any of the following? Who? _____

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart Attack ^{v173} or Stroke ^{v171} (before age 50) | <input type="checkbox"/> Mental Illness or Suicide ^{v170} | <input type="checkbox"/> Chemical Dependency ^{305.90} | <input type="checkbox"/> Diabetes ^{v180} |
| <input type="checkbox"/> High Blood Pressure ^{v174} | <input type="checkbox"/> Osteoporosis ^{v178.1} | <input type="checkbox"/> Alcoholism ^{305.00} | <input type="checkbox"/> Thyroid Problems |
| | | | <input type="checkbox"/> Cancer _____
<small>Breast v163 ovarian v164.1 colon v160</small> |

Please state age and chronic medical conditions of the following blood-related family members:

Father: _____

Mother: _____

Siblings: _____

Clinic Payment Policy

Snoqualmie Valley Hospital District (SVHD) believes that a good medical provider/patient relationship is based on good communication. We strive to provide information to our patients that clearly describe any illness, diagnosis or course of treatment. We also want to provide timely, accurate information regarding the billing arrangements we use in our practice.

Our offices are contracted with more than thirty medical insurance companies including individual, group, and HMO carriers. If you are a member of one of these plans we will bill your insurance company directly. If your insurance plan requires a co-pay or deductible for the services you receive we will collect these amounts at the time of service.

If your particular insurance plan is not one of those that we are contracted with you may still ask us to bill the company, however, insurance companies typically require that the patient pay a larger percentage of the bill if they receive services outside their contracted network. For services rendered inside or outside a particular network the co-pay is still paid at the time of service.

To determine if your insurance plan is currently contracted with SVHD please call our Clinics Billing Office at (425) 831-2310.

If you are not covered under an insurance plan you are expected to pay in full at the time of service unless payment arrangements are made prior to the service. A \$75.00 pre-payment will be collected before services are rendered. Our Clinics Billing Office is open during normal business hours (8am to 5pm) and will assist in developing a payment plan if that is required.

You may be dismissed from care for a delinquent account. We are required by state and federal regulations to employ every reasonable means to collect for our service. State regulations also require that collection fees are added to the past due amount and that they be paid by the person(s) responsible for the debt.

Personal Health Information Communication Methods

Patient Information

Name: _____ Birthdate: _____

City: _____ State: _____ Zip: _____

Permissions *(Please check ALL that apply)*

The Hospital District may leave a reminder and/or detailed message using the following methods:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Text Message: _____

Email: _____

List Preferred Communication Method: _____

The Hospital District may leave a message and/or discuss my medical information with the following individual(s):

Name & Relation: _____ Phone #: _____

Name & Relation: _____ Phone #: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any of my preferences.

Signature of Patient/Authorized Representative

Date