

### 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

<b>Person Responsible for bill:</b>				
Address(if different):			PO Box:	Birth date: / /
City:	State:	Zip Code:	Marital status:	Sex: Male or Female
Employer:		Employer address:		
<b>Is this an injury that occurred at work?</b>		<input type="checkbox"/> No <input type="checkbox"/> Yes- if so, date of injury?		Claim#:
<b>Name of Primary Insurance:</b>			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: / /	
<b>Name of Secondary Insurance:</b>			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.
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.
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.

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

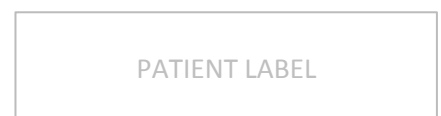
For more information on understanding your bill, setting up a payment plan, financial aid, or applying for Medicaid, please contact the Snoqualmie Valley Hospital Billing Office at (425) 831-2310.

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:



# Adult Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Single     Married     Widowed     Divorced

Occupation: \_\_\_\_\_

## Medical History *(check all that apply to you and write year of diagnosis)*

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Pap Smear <sup>622.10</sup>  | <input type="checkbox"/> B-12 Deficiency <sup>266.2</sup>           | <input type="checkbox"/> Hernia <sup>550.90</sup>                      | <input type="checkbox"/> Osteoporosis <sup>733.00</sup>             |
| <input type="checkbox"/> ADD/ADHD <sup>314.00</sup>            | <input type="checkbox"/> Cancer _____                               | <input type="checkbox"/> Herniated Disc/ Back Injury <sup>722.10</sup> | <input type="checkbox"/> Reflux Disease <sup>530.81</sup>           |
| <input type="checkbox"/> Narcotic Addiction <sup>304.01</sup>  | <input type="checkbox"/> Colon Polyps <sup>211.3</sup>              | <input type="checkbox"/> Herpes 2-Genital <sup>054.11</sup>            | <input type="checkbox"/> Seizure Disorder <sup>345.90</sup>         |
| <input type="checkbox"/> Alcoholism <sup>305.00</sup>          | <input type="checkbox"/> Congestive Heart Failure <sup>428.22</sup> | <input type="checkbox"/> High Blood Pressure <sup>401.1</sup>          | <input type="checkbox"/> Sleep Apnea <sup>327.23</sup>              |
| <input type="checkbox"/> Allergies/Hay Fever <sup>477.9</sup>  | <input type="checkbox"/> Depression <sup>311</sup>                  | <input type="checkbox"/> High Cholesterol <sup>272.2</sup>             | <input type="checkbox"/> STD  |
| <input type="checkbox"/> Anemia <sup>280.9</sup>               | <input type="checkbox"/> Diabetes <sup>250.00</sup>                 | <input type="checkbox"/> HPV-Genital Warts <sup>078.11</sup>           | <input type="checkbox"/> Stroke <sup>434.91</sup>                   |
| <input type="checkbox"/> Anxiety Disorder <sup>300.00</sup>    | <input type="checkbox"/> Eczema <sup>692.9</sup>                    | <input type="checkbox"/> Irritable Bowel Syndrome <sup>564.1</sup>     | <input type="checkbox"/> Suicide Attempt <sup>v62.84</sup>          |
| <input type="checkbox"/> Arthritis <sup>715.90</sup>           | <input type="checkbox"/> Emphysema <sup>496</sup>                   | <input type="checkbox"/> Kidney Stones <sup>592.0</sup>                | <input type="checkbox"/> Thyroid Disease <sup>244.9</sup>           |
| <input type="checkbox"/> Asthma <sup>493.90</sup>              | <input type="checkbox"/> Glaucoma <sup>365.9</sup>                  | <input type="checkbox"/> Migraine <sup>346.90</sup>                    | <input type="checkbox"/> Ulcers/PUD <sup>533.30</sup>               |
| <input type="checkbox"/> Atrial Fibrillation <sup>427.31</sup> | <input type="checkbox"/> Gout <sup>274.9</sup>                      |  | <input type="checkbox"/> Varicose Veins/ Phlebitis <sup>454.1</sup> |
| <input type="checkbox"/> Bipolar Disorder <sup>296.8</sup>     | <input type="checkbox"/> Heart Attack <sup>414.8</sup>              |  | <input type="checkbox"/> Other Serious Illness                      |
| <input type="checkbox"/> Breast Lumps <sup>610.1</sup>         | <input type="checkbox"/> Hepatitis C <sup>070.54</sup>              |  |   |

## Current Medications Doses

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medication Allergies *(include reaction):* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Hospitalizations *(include date and reason)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Surgical History *(include date and reason)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Gynecologic History *(women only)*

Date of last menstrual period: \_\_\_\_\_  
 Current birth control method: \_\_\_\_\_  
 How many times have you been pregnant? \_\_\_\_\_  
 # Miscarriage: \_\_\_\_ Age at 1st Pregnancy: \_\_\_\_  
 # Full-term Pregnancies (>37 wks): \_\_\_\_  
 # Pre-term (<37wks): \_\_\_\_ # Abortion: \_\_\_\_  
 # Ectopics: \_\_\_\_ # Multiple Births: \_\_\_\_  
 # Living Children: \_\_\_\_ Year of last Pap: \_\_\_\_\_  
 Last Mammogram: \_\_\_\_\_ Bone Density: \_\_\_\_\_  
 Colonoscopy: \_\_\_\_\_ Cholesterol: \_\_\_\_\_

## Immunization Status *(check and write last date)*

Last Tetanus *(with Pertussis Tdap)* \_\_\_\_\_  
 Gardasil/HPV Vaccine \_\_\_\_\_  
 Flu Shot \_\_\_\_\_  
 Pneumonia \_\_\_\_\_  
 Other \_\_\_\_\_

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)

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

Y N Do you drink alcohol? If yes,  Rarely  Daily  Weekend Only  Want to cut Back

Y N Do/Did you use tobacco? If yes, how many packs/other per day: \_\_\_\_\_ Quit Date: \_\_\_\_\_

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

Y N Do you feel safe in your personal relationships?

Y N Are you sexually active? If yes, do you use condoms:  Yes  No

New partner(s) since last STI exam? \_\_\_\_\_ Want STI testing?  Yes  No

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

### Family History

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

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Heart Attack <sup>v173</sup> or Stroke <sup>v171</sup> (before age 50) | <input type="checkbox"/> Mental Illness or Suicide <sup>v170</sup> | <input type="checkbox"/> Chemical Dependency <sup>305.90</sup> | <input type="checkbox"/> Diabetes <sup>v180</sup>   |
| <input type="checkbox"/> High Blood Pressure <sup>v174</sup>                                    | <input type="checkbox"/> Osteoporosis <sup>v178.1</sup>            | <input type="checkbox"/> Alcoholism <sup>305.00</sup>          | <input type="checkbox"/> Thyroid Problems   |
|   |  |  | <input type="checkbox"/> Cancer _____<br><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