Snoqualmie Valley HOSPITAL
Dedicated to quality. Devoted to community.

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: □ White □ Asian □ American Indian or Alaskan native □ Black/African American □ Native Hawaiian or Pacific Islander □ Unknown □ Decline				
Ethnicity: □ Non-Hispanic □ Hispanic □ Unknown □ Decline			Preferred Language:	Organ Donor: Y / N
Do you have an Advanced directive? □ Yes, it's located:				□ No
Do you have a Living Will? □ Yes, it's located:				□ No
Do you have a Medical Power of Attorney? □ Yes □ 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? □ No □ Yes- if so, date of injury?			Claim#:	
Name of Primary Insurance:			Subscriber's name:	
Group#:	Subscriber ID#:		Relation to subscriber: □ Self □ Spouse □ Child □ Other	
Address:			SSN:	Birth date: / /
Name of Secondary Insurance:			Subscriber's name:	
Group#:	Subscriber ID#:		Relation to subscriber: □ Self □ Spouse □ Child □ 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				

Patient Label

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. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me as the result of treatment or examination in the Hospital. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

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). We keep a record of the health care services we provide you. You may ask to see that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer.

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. You have the right to be heard if you do not believe your rights have been respected during your visit. Please contact a patient representative at (425) 831-2300 with any concerns or comments.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRATICES AND PATIENT RIGHTS AND RESPONSIBILITES

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. If delinquent, I agree to pay any interest and collection fee(s) which may accrue.

☐ **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. I understand that I may request a payment plan. To set up a payment plan, a $75.00 payment is due at time of service, with required monthly payments of $50.00 until the balance is paid in full. If my account becomes delinquent, it will be sent to collections for recovery. I agree to pay for interest and collection fee(s) which may accrue.

☐ **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. If my account becomes delinquent, it will be sent to collections for recovery. I agree to pay for interest and collection fee(s) which may accrue.

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:_____

PATIENT LABEL

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Gastroenterology Health History

Name: _____ Date: _____ Age: _____

Primary Care Provider: _____

Reason for Visit

_____

Medical History *(check all that apply to you and write age at time of diagnosis)*

☐ Reflux[530.81]
☐ Hiatal Hernia[553.3]
☐ Colon Polyps[211.3]
☐ Colon Cancer[153.9]
☐ Irritable Bowel Syndrome[564.1]
☐ Crohn's Disease[555.9]
☐ Ulcerative Colitis[556.9]
☐ Gastic Ulcers[533.30]
☐ Pancreatitis[577.0]

Test History *(provide most recent test date for all that apply to you)*

_____ Colonoscopy
_____ EGD *(Stomach Scope)*
_____ Stool Occult Blood Test
_____ Abdominal Ultrasound
_____ CEA Level
_____ Liver Blood Tests
_____ Abdominal CT Scan

Medical Conditions *(not included above)*

_____ _____
_____ _____
_____ _____

Surgical History *(include date and reason)*

_____ _____
_____ _____

Current Medications *(include dose)*

_____ _____
_____ _____
_____ _____

Medication Allergies *(include reaction)*

_____ _____
_____ _____

Continued on Reverse Side

Name: _____

Social History

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____

Circle Yes (Y) or No (N)

Y N Do you drink caffeinated products? If yes, how many per day _____

Y N Do you drink alcoholic beverages? If yes, how many drinks per week _____

Y N Do you smoke cigarettes? If yes, how many packs per day _____

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

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

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

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

Family History

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

☐ Colon Cancer[v160] ☐ Breast Cancer[v163] ☐ Ovarian Cancer[v164.1] ☐ Liver Disease

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

Father: _____

Mother: _____

Siblings: _____

Other Concerns or Questions

_____

_____

_____

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.

Continued on Reverse Side

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