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

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				

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General Consent for Admission and Treatment

Consent for Medical Treatment: I, the undersigned, hereby consent to and permit my attending physician and his/her designees, Snoqualmie Valley Hospital and its employees, and all other persons caring for me to provide treatment and care as deemed medically necessary or advisable and available to me during inpatient, outpatient, or office visit. This may include routine examinations, diagnostic tests (including radiology and laboratory), injections, and other hospital procedures and therapies. 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 to the result of treatment or examination. I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give informed consent for that procedure. Informed consent means the medical provider must disclose information to me including expected benefits and risks of a particular procedure and/or treatment.

Release of Confidential Information: I authorize Snoqualmie Valley Hospital and/or the attending physician/provider to release any information from my medical record necessary to facilitate health care claims processing and payments. This release may include specific information related to the testing, diagnosis and/or treatment of sexually transmitted diseases (including HIV), alcohol or drug abuse, and mental health/psychiatric disorders. I also consent to the release of any information as needed for post-discharge care or transfer of care to other health care facilities or agencies or as required by law. In the event a healthcare worker is exposed to my blood or body fluid in a manner that may pose a risk for transmission of a blood-borne infection during this hospitalization, office visit, or outpatient procedure, I am giving consent to be tested for blood-borne pathogens, at no cost to me, so the healthcare worker can be promptly treated. I authorize release of these test results to the exposed health worker and his/her healthcare provider.

Consent to Photograph: The taking, reproduction and use of photographs for the purpose of documentation of findings in connection with my diagnosis, care, and treatment at Snoqualmie Valley Hospital District is approved. Photographs and digital imaging are considered a part of the medical record and afforded the same protections as all other Protected Health Information.

Receipt of Electronic Mail: I acknowledge that providing my email authorizes solely Snoqualmie Valley Hospital to send me patient care announcements and patient care surveys (administered by our vendor); my information will not be sold or disclosed to any other third party.

Patient Personal Property: I am aware that Snoqualmie Valley Hospital is not liable for lost or damage of any personal property unless placed in a safe.

Notice to Outpatients: Your authorization for outpatient services is required once per calendar year.

Assignment of Insurance Benefits: I authorize my insurance benefits be paid directly to the provider of services. If my insurance plan requires copay for services received, I agree to pay the copay at the time of service. I understand that I am responsible for charges not covered by my insurance company; I understand it is my responsibility to meet the contract requirements of my health plan, and I agree to be personally responsible for this account. If payment on this account becomes delinquent, I agree to pay any interest and collection fee(s) which may accrue.

Medicare Patients: I certify the information I have provided in connection with my application under Title XVIII of the Social Security Act is correct. I request that payment for any authorized Medicare benefit be made on my behalf be made to the hospital or its employed physicians. I authorize any holder of medical information or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine my entitlement to these Medicare benefits or benefits for related services.

Self-Pay Financial Agreement: If I am currently not covered by an insurance plan, I will be personally responsible for payment. I understand if my income is within 100%-300% of Federal Poverty Guidelines, I may be eligible for a discount on services. A copy of the full payment policy or financial aid policy is available upon request at the reception desk. The full Financial Aid policy and application are also available on our website: http://snoqualmiehospital.org. For more information on understanding your bill, setting up a payment plan, financial aid, or applying for Medicaid, please contact our billing office at 425-831-2310.

Patient Certifications: I acknowledge receipt of the following informational pamphlets; Patient Rights and Responsibilities, Notice of Privacy Practices, and Advance Directives (Inpatient only).

I attempted to obtain acknowledgment but the patient declined to sign. Employee signature: _____

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT. MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT TO TREATMENT AT SNOQUALMIE VALLEY HOSPITAL DISTRICT.

_____

Patient Signature or Authorized Representative — Date

_____

Printed name if signed on behalf of the patient — Relationship

Dual-energy X-ray Absorptiometry (DEXA or DXA scan)

How to prepare for my Bone Density test

Please plan for a 30-minute office visit. You will be asked to fill out paperwork, and your bone density test takes about ten minutes. The x-ray technologist will position you flat on your back, on a padded table, and the scanner arm will pass over you.

Eat and drink normally on the day of your exam, and take all regular medications and vitamins except calcium supplements. Calcium residue may impact your diagnosis so do not take calcium pills or powder for at least 24 hours before your test.

For the easiest, fastest exam, please wear comfortable, loose-fitting clothes such as sweat pants and T-shirt or a shirt without buttons or snaps or yoga style pants and sports bra. Avoid any garments that have metal such as zippered pants or skirts, belts, shirts with buttons or snaps, and brassieres, and you will not need to undress. Although wrists are scanned occasionally, the typical DEXA scan examines the lumbar spine (lower back) and hip, so jewelry, watches, hairclips, glasses, and other accessories outside of these areas do not need to be removed. We always provide a private changing space and gown when needed.

If you recently had a barium examination or have been injected with a contrast material (dye) for a computed tomography (CT) scan or radioisotope (nuclear medicine) scan, you must wait 10-14 days before your bone density test is performed. Women: if there is a possibility of pregnancy, you should inform your physician or the technologist and postpone the exam unless there is a need for urgency.

Name: _____ **Date of Birth:** _____ **Current height:** _____

Menopause Age (Female pts only): _____ **Ethnicity:** _____ **Current weight:** _____

1. Have you had fractures or surgery of your hips or low back? Yes No *(circle one)*
2. Have you had fractures during adulthood which did not result from significant trauma (e.g., auto accident)? Yes No *(circle one)*
3. Did your parents or siblings have osteoporosis or hip fractures? Yes No *(circle one)*
4. Do you smoke? Yes No *(circle one)*
5. Have you ever taken Glucocorticoids (steroids)? Yes No *(circle one)*
6. Do you have rheumatoid arthritis? Yes No *(circle one)*
7. Do you have <u>secondary</u> osteoporosis? (e.g., resulting from a medical condition or treatment) Yes No *(circle one)*
8. Do you drink 3 or more alcoholic beverages per day? Yes No *(circle one)*
9. Are you currently being treated for osteoporosis? Yes No *(circle one)*

10. Have you ever taken any of the following medications:

☐ Actonel (risedronate) ☐ Boniva (ibandronate) ☐ Evista (raloxifene)
☐ Fosamax (alendronate) ☐ Forteo (parathyroid hormone) ☐ Dilantin
☐ HRT (estrogen/hormone therapy) ☐ Protelos (strontium ranelate) ☐ Miacalcin (calcitonin)
☐ Prolia (denosumab) ☐ Reclast (zoledronate) ☐ Calcium
☐ Vitamin D (by itself) ☐ Anti-cancer drugs ☐ Methotrexate
☐ Diuretics ☐ Thyroid meds (Synthroid, thyroxine)
☐ Other – Please specify_____

11. Do you have any of the following medical conditions:

☐ Anorexia or Bulimia ☐ Any Seizure Disorders ☐ Cancer
☐ Asthma or Emphysema ☐ End stage renal disease ☐ Hyperparathyroidism
☐ Hysterectomy ☐ Inflammatory bowel diseases
☐ Other – Please specify_____

12. What was your maximum height? _____
13. Do you perform weight bearing exercise regularly? Yes No *(circle one)*
14. Do you regularly consume dairy products? Yes No *(circle one)*
15. Do you drink caffeinated beverages? Yes No *(circle one)*

<u>IF FEMALE</u>:

16. At what age did your periods start? _____
17. Are you premenopausal? Yes No *(circle one)*
18. How many full term pregnancies have you had? _____
19. Have you ever missed your period for more than six months in a row (not including pregnancy or menopause)? Yes No *(circle one)*

MEDICAL IMAGING

DEXA EXAM SCREENING FORM

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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

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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