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				

SNOQUALMIE VALLEY HOSPITAL

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

Personal Health Information
Communication Methods

Name:_____Birthdate: _____

Permissions *(Please check ALL that apply)*

The Hospital District may leave a reminder and/or 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 the marked medical information with the following individual(s):

Clinic Records____	Hospitalization Records____	Lab Records____
Radiology Records____	Surgery Records____	HIV/AIDS____
Mental Health____	Sexually Transmitted Diseases____	Alcohol/Drug Abuse____

Name & Relation:_____Phone #:_____

Name & Relation:_____Phone #:_____

With my signature below, I acknowledge and understand that this information will be part of my medical record. In addition, the above parameters will remain in effect 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

Gastroenterology Health History

Name: _____ Date: _____

Primary Care Provider: _____

Reason for Visit: _____

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

- □ Reflux K21.9
- □ Hiatal Hernia K44.9
- □ Colon Polyps K63.5
- □ Colon CancerC18.9
- □ Irritable Bowel Syndrome K58.9
- □ Crohn's Disease K50.90
- □ Ulcerative Colitis K51.90
- □ Gastric Ulcers K25.9
- □ Pancreatitis K85.9

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)*

_____
_____
_____

Food Allergies *(include reaction)*

_____
_____
_____

Surgical History *(include date and reason)*

_____
_____
_____

_____
_____
_____

Current Medications *(include dose)*

_____
_____

_____
_____

Medication Allergies *(include reaction)*

_____
_____

_____
_____

Gastroenterology Health History Cont.

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 Stool

Family History

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

□ Colon Cancer C18.9 □ Breast Cancer C50.919 □ Ovarian Cancer C56.9 □ Liver Disease K76.89

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, co-insurance 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 Snoqualmie Valley Hospital is currently contracted with your insurance plan, please call our Billing Office at (425) 831-2310.

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.

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.