

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

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 Reports _____	Surgery Reports _____	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

Pediatric Health History (Birth - 18 Years Old)

Name: _____ Birthday: _____

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 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)*

Food Allergies *(include reaction)* _____

Immunization Status *(check and write last date)*

We will survey state immunization registry for you.

Last Tetanus (Tdap with Pertussis) : _____

Gardasil/HPV Vaccine: _____

Flu Shot: _____

Gynecologic History *(females only)*

Has first period occurred? Y N If yes, at what age? ____

Date of last menstrual period: _____

Current birth control method: _____

Pediatric Health History Cont. (Birth - 18 Years Old)

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

Family History

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart Attack ^{I21.3} or Stroke ^{I63.9} (before age 50) | <input type="checkbox"/> Mental Illness or Suicide | <input type="checkbox"/> Alcoholism ^{F10.988} | <input type="checkbox"/> Diabetes ^{E11.9} |
| <input type="checkbox"/> High Blood Pressure ^{I10.0} | <input type="checkbox"/> Osteoporosis ^{M81.0} | <input type="checkbox"/> Drug Dependence ^{F19.20} | <input type="checkbox"/> Thyroid Problems ^{E07.9} |
| | | | <input type="checkbox"/> Cancer _____ |

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, co-insurance or deductible for the services you receive, we will collect these. If you have the ability to pay and do not pay your copay on the same day of service, a \$35.00 late fee will be charged to you..

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.

Snoqualmie Valley Hospital is committed to ensuring our patients get the care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and state law requires hospitals to provide free and discounted care to eligible patients. You may qualify for free or discounted care based on family size and income, even if you have health insurance.

How to Apply: Any patient may apply to receive financial assistance/charity care by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- When you are checking in or checking out of the clinics;
- By telephone: 425-831-2310
- Our website at: <http://snoqualmiehospital.org/wp-content/uploads/Financial-Aid-Application-Packet.pdf>
- In person: 9801 Frontier Ave SE, Snoqualmie or 35020 SE Kinsey Street Snoqualmie, WA 98065
- To obtain documents via mail free of charge: Business Office 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. We refer delinquent accounts to:

Merchants Credit Association, PO Box 7416, Bellevue, WA 98008 Phone: 425-643-2613.

If English is Not Your First Language: Translated versions of the application form, are available upon request. at the time of service.