

PATIENT INFORMATION

Last Name (Legal)		First Name, Middle Name (Legal)		Preferred Name	
Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Agender <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male <input type="checkbox"/> Bigender <input type="checkbox"/> Cis <input type="checkbox"/> Prefer to decline		Preferred Pronouns <input type="checkbox"/> She/Her <input type="checkbox"/> He/Him <input type="checkbox"/> They/Them <input type="checkbox"/> Other _____		Sex assigned at birth <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown	Date of Birth
SSN	Mailing Address		City	State	Zip Code
Phone	E-Mail		Would you like electronic access to your chart? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Marital Status	Race (Select all that apply) <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Decline		Ethnicity <input type="checkbox"/> Hispanic or Latino/a, Latinx <input type="checkbox"/> Not Hispanic, Latino/a, Latinx <input type="checkbox"/> Decline	Do you need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred Language	Communication Assistance? <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Vision <input type="checkbox"/> Other: _____		Do you have a companion needing Hearing or Speech Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
May we leave a message for appointments or Normal lab values? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Care Provider <input type="checkbox"/> No Primary Care provider		Are you an Organ Donor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Emergency Contact Name		Emergency Contact Phone		Relationship to patient	
Do you have an Advanced directive? <input type="checkbox"/> Yes, it's located at: _____ <input type="checkbox"/> No Do you have a Living Will? <input type="checkbox"/> Yes, it's located at: _____ <input type="checkbox"/> No					
Do you have a Medical Power of Attorney? <input type="checkbox"/> Yes, it's located at _____ <input type="checkbox"/> No					

RESPONSIBLE PARTY (If different from patient i.e.: Parent, Legal Guardian/Healthcare Durable Power of Attorney)

Last Name (Legal)		First Name, Middle Name (Legal)		Date of Birth	
Mailing Address (if different)			City	State	Zip Code
Phone	SSN	Relationship to Patient	Marital status:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> X	

INSURANCE/CLAIM INFORMATION

Worker's Comp Claim? <input type="checkbox"/> Yes, date of injury _____ Body Part Injured _____ Claim Number _____					
Motor Vehicle Accident? Date of Injury _____ Auto Insurance Carrier _____ Claim/Policy Number _____					
Primary Insurance Name		Subscriber Name		Subscriber ID Number	
Date of Birth	SSN	Phone Number	Same Address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Patient	
Employer Name		Subscriber Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			
Secondary Insurance Name		Subscriber Name		Subscriber ID Number	
Date of Birth	SSN	Phone Number	Same Address? <input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Patient	
Employer Name		Subscriber Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			

MEDICARE RECIPIENTS

Are you receiving benefits from any of the following programs: <input type="checkbox"/> Black Lung <input type="checkbox"/> Veterans Affairs <input type="checkbox"/> Disability <input type="checkbox"/> Government Research <input type="checkbox"/> Kidney Dialysis or Transplant <input type="checkbox"/> ESRD If Yes to any above programs, date benefits began: _____	
Are you or your spouse employed? <input type="checkbox"/> Self <input type="checkbox"/> Spouse If no, year of retirement: <input type="checkbox"/> Self _____ <input type="checkbox"/> Spouse _____	Does the employer that sponsors your Group Health plan employ 20 employees or more? <input type="checkbox"/> Yes <input type="checkbox"/> No
If employed, do you or your spouse have group health plan coverage from current employment? Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the employer that sponsors your spouse's Group Health plan employ 20 employees or more? <input type="checkbox"/> Yes <input type="checkbox"/> No

SNOQUALMIE VALLEY HEALTH

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 Reports _____	HIV/AIDS _____
Mental Health _____	Sexually Transmitted Infection _____	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

Adult Health History

Name: _____ Date: _____

Single Married Widowed Divorced Occupation: _____

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> ADD/ADHD ^{F90.8} | <input type="checkbox"/> B-12 Deficiency ^{E53.8} | <input type="checkbox"/> Hepatitis ^{CB18.2} | <input type="checkbox"/> Osteoporosis ^{M81.0} |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> Hernia ^{K46.9} | <input type="checkbox"/> Reflux Disease ^{Z87.19} |
| <input type="checkbox"/> Drug Addiction ^{F19.20} | <input type="checkbox"/> Colon Polyps ^{K63.5} | <input type="checkbox"/> Herniated Disc/Back
pain ^{M51.9} | <input type="checkbox"/> Seizure Disorder ^{G40.909} |
| <input type="checkbox"/> Alcoholism ^{F10.988} | <input type="checkbox"/> Depression ^{F33.9} | <input type="checkbox"/> Herpes 2-Genital ^{A60.9} | <input type="checkbox"/> Sleep Apnea ^{G47.30} |
| <input type="checkbox"/> Allergies ^{J30.2} | <input type="checkbox"/> Diabetes ^{E11.9} | <input type="checkbox"/> High Cholesterol ^{E78.0} | <input type="checkbox"/> STI ^{A64} |
| <input type="checkbox"/> Anemia ^{D64.9} | <input type="checkbox"/> Eczema ^{L20.9} | <input type="checkbox"/> High blood pressure ^{I10.0} | <input type="checkbox"/> Stroke ^{I63.9} |
| <input type="checkbox"/> Anxiety Disorder ^{F41.9} | <input type="checkbox"/> Emphysema ^{J43.9} | <input type="checkbox"/> HPV-Genital Warts ^{B97.7} | <input type="checkbox"/> Suicide Attempt ^{T14.91} |
| <input type="checkbox"/> Arthritis ^{M19.90} | <input type="checkbox"/> Glaucoma ^{H42} | <input type="checkbox"/> Irritable Bowel ^{K58.8} | <input type="checkbox"/> Thyroid Disease ^{E07.9} |
| <input type="checkbox"/> Asthma ^{J45.909} | <input type="checkbox"/> Gout ^{M10.0} | <input type="checkbox"/> Kidney Stones ^{N20.0} | <input type="checkbox"/> Ulcers/PUD ^{K28.9} |
| <input type="checkbox"/> Atrial Fibrillation ^{I48.91} | <input type="checkbox"/> Heart Attack ^{I21.3} | <input type="checkbox"/> Migraine ^{G43.909} | <input type="checkbox"/> Varicose
Veins/Phlebitis ^{Z86.79} |
| <input type="checkbox"/> Bipolar Disorder ^{F31.9} | <input type="checkbox"/> Heart Failure ^{I50.9} | | <input type="checkbox"/> Other Serious Illnesses:
_____ |
| <input type="checkbox"/> Breast lumps ^{N63} | | | |

Current Medications Doses

Medication Allergies *(include reaction)*

Food 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? _____
Number of living children: _____
Date of last Pap Smear: _____

Immunization Status *(check and write last date)*

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

Adult Health History Cont.

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? Yes No 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"/> Swelling of Ankles | <input type="checkbox"/> Strokes | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Numbness | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Spitting up Blood | <input type="checkbox"/> Memory Loss or
Confusion | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Depression | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Burning with
Urination | <input type="checkbox"/> Heat or Cold
Intolerance | <input type="checkbox"/> Regurgitation |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Excessive Thirst or
Urination | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Bleeding or Bruising
Tendency | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Swallowing Difficulty | <input type="checkbox"/> Recent Change in
Bowel Habits |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Headaches | | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Chest Pain | <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} | <input type="checkbox"/> Mental Illness or
Suicide | <input type="checkbox"/> Alcoholism ^{F10.988} | <input type="checkbox"/> Diabetes ^{E11.9} |
| <input type="checkbox"/> Stroke ^{I63.9} | <input type="checkbox"/> Osteoporosis ^{M81.0} | <input type="checkbox"/> Drug Dependence ^{F19.20} | <input type="checkbox"/> Thyroid Problems ^{E07.9} |
| <input type="checkbox"/> High Blood Pressure ^{I10.0} | | | <input type="checkbox"/> Cancer _____ |

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

Father: _____

Mother: _____

Siblings: _____

Preventative Exams and Problem Visits

At first a preventive visit and office visit may seem similar, but there is a difference. Knowing which to schedule can help ease any confusion.

You schedule preventive visits which are annual physicals, well child exams and wellness exams to help prevent or detect any health concerns. This is also known as your annual wellness exam or annual health maintenance exam. Confusion comes when at your annual checkup you want to discuss or receive treatment for a new or existing condition that requires action. This is where a preventive visit can become an office visit and your bill can be impacted.

You schedule an office visit, or problem-related service, for problem focused care, meaning you notice symptoms and want to talk with your provider. In your preventive visit if a problem is addressed and needs to be treated, your provider's office is required to bill as a separate office visit, due to action for treatment needed.

What is a preventive visit?

- Complete physical exam (annual health maintenance exam)
- Blood pressure, blood glucose and cholesterol screening tests
- Pelvic exams, pap smear
- Mammograms
- Prostate and colorectal cancer screenings
- Sexually transmitted infection testing
- Thorough review of medical history, general health and well-being
- Vaccination review and update
- Developmental screenings
- Evaluation of future risks

What is an office visit?

- Diagnosing and monitoring specific medical conditions
- Addressing medical concerns and treatment plans
- Medication refills
- Specialist referrals
- Testing/lab results
- Addressing new or worsening symptoms
- Depending on benefits an office visit can result in additional costs

Before scheduling an appointment state clearly whether this will be a wellness exam or if this appointment will be to discuss and treat new health concerns or symptoms. If a wellness exam is spent on specific or new health issues and treated it will no longer be considered a preventive visit, and it will be billed as an office visit.

Thank you for your understanding! Your Snoqualmie Valley Health Team.

Signature _____ Date _____

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 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.