Snoqualmie Valley Health

PATIENT INFORMATION

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

INSURANCE/CLAIM INFORMATION

Worker's Comp Claim? ☐ 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? ☐ Yes ☐ No	Relationship to Patient
Employer Name		Subscriber Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Retired		
Secondary Insurance Name		Subscriber Name	Subscriber ID Number	
Date of Birth	SSN	Phone Number	Same Address? ☐ Yes ☐ No	Relationship to Patient
Employer Name		Subscriber Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Retired		

MEDICARE RECIPIENTS

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