

PATIENT INFORMATION

Last Name (Legal)		First Name, Middle Name (Legal)		Preferred Name			
Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Agender <input type="checkbox"/> Bigender <input type="checkbox"/> Cis or cisgender <input type="checkbox"/> Demiboy <input type="checkbox"/> Demigirl <input type="checkbox"/> Gender Fluid <input type="checkbox"/> Genderqueer <input type="checkbox"/> Man or Masculine <input type="checkbox"/> Woman or Feminine <input type="checkbox"/> Two Spirit <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to Disclose <input type="checkbox"/> Unknown		Preferred Pronouns <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other <input type="checkbox"/> Choose not to Disclose		Sex Assigned at Birth <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown <input type="checkbox"/> Uncertain <input type="checkbox"/> Choose not to Disclose		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			
Preferred Language		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 or Latino/a, Latinx <input type="checkbox"/> Decline		Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Marital Status		Employer		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			
Emergency Contact Name			Emergency Contact Phone			Relationship to patient	
Does your emergency contact have the same address?			If no, please list their address:				
Does your emergency contact need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No							

RESPONSIBLE PARTY (i.e. Parent or Legal Guardian if patient is under 18 years old; Healthcare Durable Power of Attorney)

Last Name (Legal)		First Name, Middle Name (Legal)		Relationship to Patient			
Mailing Address (if different from patient)		City		State	Zip Code	Phone Number	

INSURANCE

Primary Insurance Company Name		Member ID Number		Group Number		Subscriber Name	
Relationship to Patient		Social Security Number		Date of Birth		Phone Number	
Subscribers Employer Name		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			Employer Phone Number		

Secondary Insurance Company Name		Member ID Number		Group Number		Relationship to Patient	
Subscribers Name (Policy Holder)		Social Security Number		Date of Birth		Phone Number	
Subscribers Employer Name		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			Employer Phone Number		

MEDICARE RECIPIENTS

Are you receiving Medicare benefits based on age? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you receiving Medicare? <input type="checkbox"/> Part A <input type="checkbox"/> Part B	
Do you have a Medicare Advantage Plan (Part C)? <input type="checkbox"/> Yes <input type="checkbox"/> No		(If yes) Insurance Company Name _____	
Do you have a Medicare Supplemental Plan (Plan F, G, or N) <input type="checkbox"/> Yes <input type="checkbox"/> No		(If yes) Insurance Company Name _____	

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 bloodborne 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 and Notice of Privacy Practices, and for Inpatient Advance Directive.

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)

PLEASE CHECK ALL THAT APPLY

Clinic Records _____	Hospitalization Records _____	Lab Records _____
Radiology Records _____	Surgery Reports _____	HIV/AIDS _____
Mental Health _____	Sexually Transmitted Infection _____	Alcohol/Drug Abuse _____

Name and Relation _____	Phone _____
-------------------------	-------------

Name and 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 _____

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 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? _____

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 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 applying 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.