PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)			Preferred Name
Gender Identity ☐ Female ☐ Transgender Female ☐ Non-Binary ☐ Agender ☐ Other ☐ Male ☐ Transgender Male ☐ Bigender ☐ Cis ☐ Prefer to decline	Preferred Pronouns ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other_____		Sex assigned at birth ☐ Female ☐Male ☐ Unknown	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 Health 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 Health 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 Health 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 Health 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 Health 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 HEALTH.

_____

Patient Signature or Authorized Representative Date

_____

Printed name if signed on behalf of the patient Relationship

Communication Authorizations of Personal Health Information (PHI)

Snoqualmie Valley Health

Patient Name: _____

Date of Birth: _____

Preferred Phone: _____ OK to Leave Message? Yes ☐ No ☐

Preferred Email: _____

Snoqualmie Valley Health District (SVH) will not discuss any of your personal health information (PHI) unless otherwise stated. If you would like to authorize another individual (i.e. a friend or loved one, not an organization or other healthcare provider) that would give the hospital district permission to speak with them, please list them below.

1. _____
Name and Relationship to Patient Phone Number

Regarding my:
Check all that apply. Please disregard if parent or guardian.

Clinic Records ☐ Billing ☐ Mental Health ☐ Sexually Transmitted Disease ☐

Hospital Records ☐ Drug & Alcohol ☐ HIV/Aids ☐

2. _____
Name and Relationship to Patient Phone Number

Regarding my:
Check all that apply. Please disregard if parent or guardian.

Clinic Records ☐ Billing ☐ Mental Health ☐ Sexually Transmitted Disease ☐

Hospital Records ☐ Drug & Alcohol ☐ HIV/Aids ☐

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 for 1 year or until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change any of my preferences.

_____

Patient Signature or Authorized Representative Date

_____

Printed Name if Signed on Behalf of Patient Relationship

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)*

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

Current Medications Doses

_____ _____
_____ _____
_____ _____

Medication Allergies *(include reaction)*

_____
_____

Food Allergies *(include reaction)*

_____
_____

Hospitalizations *(include date and reason)*

_____
_____
_____

Surgical History *(include date and reason)*

_____
_____
_____

Gynecologic History *(females 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):* _____
Gardisil/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)*

- □ 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? _____

- □ Heart Attack I21.3
- □ Stroke I63.9
- □ High Blood Pressure I10.0
- □ Mental Illness or Suicide
- □ Osteoporosis M81.0
- □ Alcoholism F10.988
- □ Drug Dependence F19.20
- □ Diabetes E11.9
- □ Thyroid Problems E07.9
- □ 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 Health believes that a good medical provider/patient relationship is based on strong 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 at the time 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 Health 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
- On our website at: https://snoqualmievalleyhealth.org/wp-content/uploads/2024/03/2024-Financial-Aid-Packet_English-1.pdf
- In person: 9801 Frontier Ave SE, Snoqualmie WA 98065 or 35020 SE Frontier 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.