PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)		Preferred Name
Gender Identity □ Female □ Male □ Transgender Male □ Transgender Female □ Non-Binary □ Agender □ Bigender □ Cis or cisgender □ Demiboy □ Demigirl □ Gender Fluid □ Genderqueer □ Man or Masculine □ Woman or Feminine □ Two Spirit □ Other:_____ □ Choose not to Disclose □ Unknown	Preferred Pronouns ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other ☐ Choose not to Disclose	Sex Assigned at Birth ☐ Female ☐ Male ☐ Intersex ☐ Unknown ☐ Uncertain ☐ 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? ☐ Yes ☐ No		
Preferred Language	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 or Latino/a, Latinx ☐ Decline	Do you need an interpreter? ☐ Yes ☐ No	
Marital Status	Employer	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Active Military ☐ Disabled ☐ 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? ☐ Yes ☐ 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 ☐Full-Time ☐Part-Time ☐Student ☐Active Military ☐ Disabled ☐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 ☐Full-Time ☐ Part-Time ☐ Student ☐Active Military ☐ Disabled ☐ Retired	Employer Phone Number	

MEDICARE RECIPIENTS

Are you receiving Medicare benefits based on age? ☐ Yes ☐ No	Are you receiving Medicare? ☐ Part A ☐ Part B
Do you have a Medicare Advantage Plan (Part C)? ☐ Yes ☐ No	(If yes) Insurance Company Name_____
Do you have a Medicare Supplemental Plan (Plan F, G, or N) ☐ Yes ☐ No	(If yes) Insurance Company Name _____

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 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

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

Communication Authorizations of Personal Health Information (PHI)

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

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)*

_____

_____

_____

_____

Family History *(include relation and medical condition)*

_____

_____

_____

_____

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.