Snoqualmie Hospital
REHABILITATION CLINIC

PATIENT INFORMATION

Patients last name:			First:	MI:
Street Address:			PO Box:	Birth date: / /
City:	State:	Zip Code:	Marital status:	Sex: Male or Female
Social Security:	1st phone:		2nd phone:	
Email address:			Would you like electronic access to your chart? Y / N	
May we leave a message for appointments or Normal lab values: Y / N			If yes, primary number:	
Primary Care Physician:			City:	State:
Race: □ White □ Asian □ American Indian or Alaskan native □ Black/African American □ Native Hawaiian or Pacific Islander □ Unknown □ Decline				
Ethnicity: □ Non-Hispanic □ Hispanic □ Unknown □ Decline			Preferred Language:	Organ Donor: Y / N
Do you have an Advanced directive? □ Yes, it's located:				□ No
Do you have a Living Will? □ Yes, it's located:				□ No
Do you have a Medical Power of Attorney? □ Yes □ No			POA name:	Phone:

INSURANCE/GUARANTOR INFORMATION

Person Responsible for bill:				
Address(if different):			PO Box:	Birth date: / /
City:	State:	Zip Code:	Marital status:	Sex: Male or Female
Employer:	Employer address:			
Is this an injury that occurred at work? □ No □ Yes- if so, date of injury?			Claim#:	
Name of Primary Insurance:			Subscriber's name:	
Group# :	Subscriber ID# :		Relation to subscriber: □ Self □ Spouse □ Child □ Other	
Address:			SSN:	Birth date: / /
Name of Secondary Insurance:			Subscriber's name:	
Group# :	Subscriber ID# :		Relation to subscriber: □ Self □ Spouse □ Child □ Other	
Address:			SSN:	Birth date: / /

IN CASE OF EMERGENCY

Primary Contact:			Phone:	
Address:	City:	State:	Relationship to patient:	
Secondary Contact:			Phone:	
Address:	City:	State:	Relationship to patient:	

MEDICARE PATIENTS ONLY

Are you receiving benefits from any of the following programs: Black Lung: Y / N Veteran Affairs: Y / N Disability: Y / N				
Government research: Y / N If Yes, date benefits began:				
Kidney Dialysis or Transplant: Y / N ESRD Y / N If yes, date benefits began:				
Are you employed: Y / N Spouse: Y / N			Date of retirement Self:	Spouse:
Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? Self or Spouse				
Does the employer that sponsors your GHP employ 20 or more employees? Y / N				

Patient Label

Snoqualmie Hospital
REHABILITATION CLINIC

Snoqualmie Valley Hospital
Consent for Treatment/Notice of Privacy Practices/Patient Rights & Responsibilities

AUTHORIZATION AND CONSENT FOR TREATMENT

I authorize Snoqualmie Valley Hospital and its designated representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. 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 the result of treatment or examination in the Hospital. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

Notice of Privacy Practices: This Notice of Privacy Practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We keep a record of the health care services we provide you. You may ask to see that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer.

Patient Rights and Responsibilities: This brochure outlines your patient rights including your rights to be informed of medical decisions, to participate in the development and implementation of your plan of care, to privacy during your care as well as to receive care in a safe setting. You have the right to be heard if you do not believe your rights have been respected during your visit. Please contact a patient representative at (425) 831-2300 with any concerns or comments.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRATICES AND PATIENT RIGHTS AND RESPONSIBILITES

I hereby acknowledge receipt of the Notice of Privacy Practices_____(Initials) and Patient Rights and Responsibilities_____(Initials)

ASSIGNMENT OF INSURANCE BENEFITS AND CLINIC/HOSPITAL FINANCIAL AGREEMENTS:

☐ **Assignment of Insurance Benefits**: I authorize my insurance benefits to be paid directly to the provider of services. If my insurance company determines that a particular service is not covered reasonable or necessary, I agree to be personally responsible for this account. If delinquent, I agree to pay any interest and collection fee(s) which may accrue.

☐ **Clinic Self-Pay Financial Agreement**: I am currently not covered by an insurance plan and will be personally responsible for payment of services to me at Snoqualmie Valley Hospital Clinics. I am expected to pay in full at time of service. I will receive a 30% discount at time of up-front payment. I understand that I may request a payment plan. To set up a payment plan, a $75.00 payment is due at time of service, with required monthly payments of $50.00 until the balance is paid in full. If my account becomes delinquent, it will be sent to collections for recovery. I agree to pay for interest and collection fee(s) which may accrue.

☐ **Hospital Self-Pay Financial Agreement**: I am currently not covered by an insurance plan and will be personally responsible for payment of services provided to me at Snoqualmie Valley Hospital. I understand that I may request a payment plan or financial aid assistance if I meet the qualifications. If my account becomes delinquent, it will be sent to collections for recovery. I agree to pay for interest and collection fee(s) which may accrue.

Please note that additional charges may accrue after your initial visit, such as lab charges.

For more information on understanding your bill, setting up a payment plan, financial aid, or applying for Medicaid, please contact the Snoqualmie Valley Hospital Billing Office at (425) 831-2310.

I CERTIFY THAT I HAVE READ THE FOREGOING AND THAT I UNDERSTAND ITS CONTENT.

Patient or Authorized Representative:_____ Date:_____

Printed name if signed on behalf of patient:_____ Relationship:_____

Witness:_____

PATIENT LABEL

Personal Health Information
Communication Methods

Patient Information

Name: _____ Birthdate: _____

City: _____ State: _____ Zip: _____

Permissions *(Please check ALL that apply)*

The Hospital District may leave a reminder and/or detailed 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 my medical information with the following individual(s):

Name & Relation:_____ Phone #: _____

Name & Relation:_____ Phone #: _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by 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

Clinic Payment & No Show 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 or deductible for the services you receive we will collect these amounts at the time of service.

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.

To determine if your insurance plan is currently contracted with SVHD please call our Clinics Billing Office at (425) 831-2310.

If you are not covered under an insurance plan you are expected to pay in full at the time of service unless payment arrangements are made prior to the service. A $75.00 pre-payment will be collected before services are rendered. Our Clinics Billing Office is open during normal business hours (8am to 5pm) and will assist in developing a payment plan if that is required.

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.

No Show Policy

We are sincerely dedicated in helping you meet your therapy goals. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in quicker recovery and better outcomes.

We request that you give 24 hours notice if you need to cancel or reschedule an appointment. Late notice cancellations or not showing up for an appointment without any notice affects your care as well as the care of other clients who could have been seen at that time.

For these reasons, our no show policy states that after 3 unexcused no shows or cancels with less than 24 hours notice, you will be placed on a same-day call list. You will no longer be eligible to schedule appointments in advance. You will be responsible for calling the day you want to be seen and you will be scheduled for that day based upon availability.

I understand and agree to the terms on this form.

_____ _____

Signature of Patient/Authorized Representative Date

Snoqualmie Hospital
REHABILITATION CLINIC

Medical Profile

Name: _____ Date: _____ Age: _____

Occupation: _____ Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous

Physical position at work: ☐ Sitting ☐ Standing ☐ Other: _____

Primary Care Provider: _____ Referring Provider: _____

Symptoms *(please write in answer and / or check all that apply)*

Reason(s) for Visit: _____

How long has this episode of pain / symptoms been present? _____

Have you had previous therapy this year? ☐ No ☐ Yes, explain: _____

Type of Injury:
☐ None / No Specific Incident
☐ Motor Vehicle Accident
☐ Work Injury
☐ Sports
☐ Other: _____

Symptoms are present:
☐ Morning ☐ Mid-Day ☐ Evening

Symptoms are worse:
☐ Morning ☐ Mid-Day ☐ Evening

Symptoms are better:
☐ Morning ☐ Mid-Day ☐ Evening

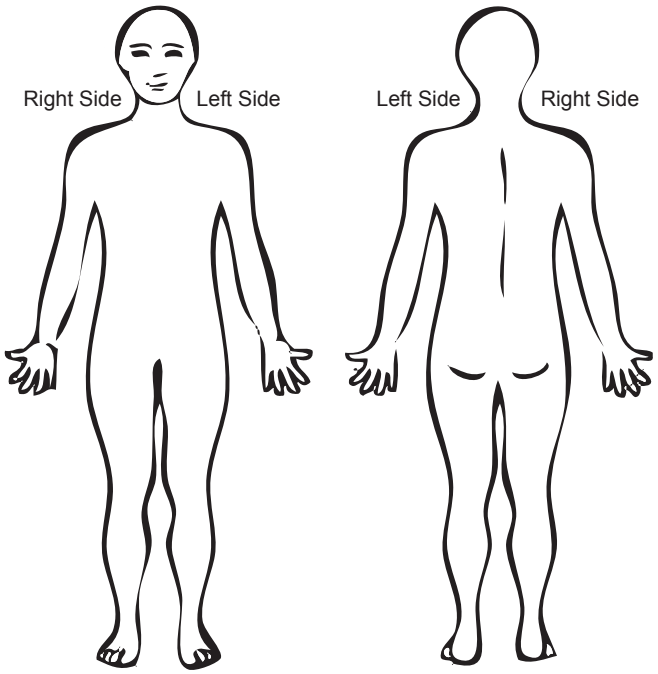
Current Medications *(check all that apply)*

☐ No Medication
☐ Steroid *(i.e. Cortisone)*
☐ Muscle Relaxant
☐ Anti-Inflammatory
☐ Pain Killer
☐ Blood Pressure Medication
☐ Anti-Coagulant *(blood thinner)*
☐ Heart Medication
☐ Medication for Diabetes
☐ Other: _____

Pain or Discomfort Location(s)

Mark all the areas you are having symptoms on the drawing below.

Pain: XX Numbness: >> Tingling: //



Please place a mark that indicates how much pain you are experiencing on the scale below:

0 2 4 6 8 10

No pain Intolerable

Pain Management Techniques *(check any that you have utilitzed to self-manage your symptoms)*

- ☐ Lying Down
- ☐ Changing Positions
- ☐ Sitting
- ☐ Walking
- ☐ Stretching
- ☐ Exercise
- ☐ Medication
- ☐ Other: _____

Activity Tolerance *(check any that cause you problems or pain)*

- ☐ Reaching Overhead
- ☐ Driving
- ☐ Cooking
- ☐ Squatting / Kneeling
- ☐ House Cleaning
- ☐ Yard Work
- ☐ Up / Down Stairs
- ☐ Lifting *(please list):* _____
- ☐ Recreation / Sports *(please list)*: _____
- ☐ Personal Care *(dressing, bathing, grooming)*
- ☐ Standing: How long before an increase in pain? _____ mins / _____ hrs
- ☐ Sitting: How long before an increase in pain? _____ mins / _____ hrs
- ☐ Walking: How long before an increase in pain? _____ mins / _____ hrs
- ☐ Running: How long before an increase in pain? _____ mins / _____ hrs
- ☐ Difficulty falling asleep: Sleep position: _____
- ☐ Awakened from sleep _____times per night: Sleep position: _____
- ☐ Other: _____

Treatment History *(check all services you have received for this injury / episode)*

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Massage Therapy
- ☐ Chiropractor
- ☐ Podiatrist
- ☐ General Practitioner
- ☐ Cardiologist
- ☐ OB / Gynecologist
- ☐ Sports Medicine Physician
- ☐ Orthopedist
- ☐ Neurologist
- ☐ ER Care
- ☐ Lab *(Bloodwork)*
- ☐ X-Rays
- ☐ CT Scan
- ☐ MRI
- ☐ EMG/NCV
- ☐ Myelogram
- ☐Arthrogram
- ☐ Pulmonologist
- ☐ Hospitalization: _____
- ☐ Other: _____

Medical History *(check the box if you have ever had any of the following issues)*

- ☐ Asthma, Bronchitis / Emphysema
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Coronary *(Heart)* Disease / Angina
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Heart Attack/Surgery
- ☐ Stroke / TIA
- ☐ Congestive Heart Disease
- ☐ Blood Clot / Emboli
- ☐ Epilepsy / Seizures
- ☐ Thyroid Disease / Goiter
- ☐ Anemia
- ☐ Spitting Up Blood
- ☐ Infectious Disease
- ☐ Diabetes
- ☐ Cancer / Chemo / Radiation
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Sleeping Difficulty
- ☐ Anxiety / Depression
- ☐ Memory Loss / Confusion
- ☐ Depression
- ☐ Psychiatric Treatment
- ☐ Severe / Frequent Headaches
- ☐ Easily Bleed / Bruise
- ☐ Numbness / Tingling
- ☐ Dizziness / Fainting
- ☐ Vision / Hearing Problems
- ☐ Bowel / Bladder Problems
- ☐ General Weakness
- ☐ Weight Loss / Energy Loss
- ☐ Hernia
- ☐ Varicose Veins
- ☐ Currently Pregnant
- ☐ Use Tobacco *(currently)*
- ☐ Pins / Metal Implants
- ☐ Joint Replacement Surgery
- ☐ Neck Injury / Surgery
- ☐ Shoulder Injury / Surgery
- ☐ Elbow / Hand Injury / Surgery
- ☐ Back Injury / Surgery
- ☐ Hip Injury / Surgery
- ☐ Leg / Foot / Ankle Injury / Surgery
- ☐ Knee Injury / Surgery
- ☐ Medication Allergies: _____
- ☐ Foods Allergies: _____
- ☐ Allergy to Tape
- ☐ Allergy to Beeswax
- ☐ Allergy to Lanolin
- ☐ Other Allergies: _____

History of Falls

- ☐ One Fall in Past Year
- ☐ 2+ Falls in Past Year
- ☐ Injury Related to a Fall *(list)*: _____ _____

Snoqualmie Hospital
REHABILITATION CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Please Print

√ _____
Full Name (include middle initial)
√ _____
Previous name if applicable
√ _____
Date of Birth and consumer number
√ _____
Daytime Phone number

I HEREBY REQUEST AND AUTHORIZE THE FOLLOWING EXCHANGE/RELEASE OF INFORMATION

INFORMATION TO BE RELEASED BY:	INFORMATION TO BE RELEASED TO:
Organization: **Snoqualmie Hospital Rehabilitation Clinic**	Organization / Individual:
Address: **38565 SE River Street**	Address:
Address: **Snoqualmie, WA 98065**	Address
Phone: **(425) 831-2376** Fax: **(425) 831-3071**	Phone: Fax **:**

PURPOSE OF DISCLOSURE: □Continuing Care □Legal □Insurance □At Patient Request
Other: (explain)

WRITTEN INFORMATION TO BE DISCLOSED:
Dates: From___To_____

- □ Clinic Records _____
- □ Hospitalization Records _____
- □ Radiology Reports _____
- □ Radiology Films/CD _____
- □ Lab Records_____
- □ Home Care Records _____
- □ Skilled Nursing Facility Records _____
- □ Surgery Reports _____
- □ Other_____

RELEASE REQUIRING SPECIFIC CONSENT:
My initials and signature below authorize the release of healthcare information relating to testing, diagnosis or treatment for:
HIV/AIDS _____ Mental Health _____ Sexually Transmitted Diseases _____ Alcohol/Drug Abuse_____
Reproductive Care (minors only)_____

MINORS – A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care including, but not limited to, contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older. (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

√_____ √_____ _____
Date: **Signature of patient or patient's authorized representative** Relationship to patient (if not patient)
□ check if patient is a minor

Witness: _____

Authorization will automatically expire 90 days from the date of my signature. I hereby release Snoqualmie Valley Hospital from all legal responsibilities or liability that may arise from disclosure of medical records in reliance upon this Authorization.
Federal and State Laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a healthcare provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected in certain situations.

Revocation: This authorization may be revoked at any time by submitting a written request to:
(Note – current revocation does not apply to information already disclosed)

Snoqualmie Valley Hospital
Medical Records Department
9801 Frontier Avenue SE
Snoqualmie, WA 98065