

### 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: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan native <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Decline					
Ethnicity: <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Decline			Preferred Language:		Organ Donor: Y / N
Do you have an Advanced directive? <input type="checkbox"/> Yes, it's located:					<input type="checkbox"/> No
Do you have a Living Will? <input type="checkbox"/> Yes, it's located:					<input type="checkbox"/> No
Do you have a Medical Power of Attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No			POA name:		Phone:

### INSURANCE/GUARANTOR INFORMATION

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



**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 PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES**

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: \_\_\_\_\_



# 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.

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Signature of Patient/Authorized Representative

---

Date

# 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: \_\_\_\_\_

**Pain or Discomfort Location(s)**

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

Pain: XX      Numbness: >>      Tingling: //

Symptoms are present:

- Morning  Mid-Day  Evening

Symptoms are worse:

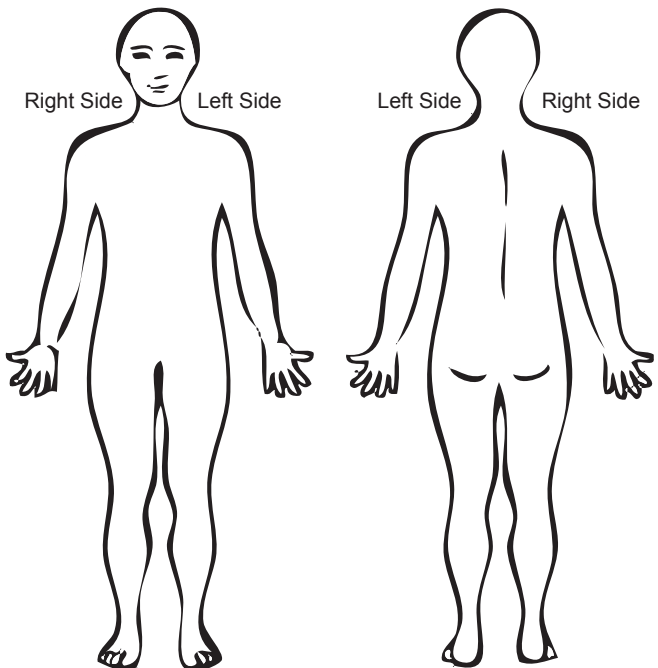
- Morning  Mid-Day  Evening

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: \_\_\_\_\_



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



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

- |   |                                  |                                     |                                       |
|---|----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Lying Down         | <input type="checkbox"/> Sitting | <input type="checkbox"/> Stretching | <input type="checkbox"/> Medication   |
| <input type="checkbox"/> Changing Positions | <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise   | <input type="checkbox"/> Other: _____ |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Reaching Overhead               | <input type="checkbox"/> Recreation / Sports (please list): _____                            |
| <input type="checkbox"/> Driving                         | <input type="checkbox"/> Personal Care (dressing, bathing, grooming)                         |
| <input type="checkbox"/> Cooking                         | <input type="checkbox"/> Standing: How long before an increase in pain? ____ mins / ____ hrs |
| <input type="checkbox"/> Squatting / Kneeling            | <input type="checkbox"/> Sitting: How long before an increase in pain? ____ mins / ____ hrs  |
| <input type="checkbox"/> House Cleaning                  | <input type="checkbox"/> Walking: How long before an increase in pain? ____ mins / ____ hrs  |
| <input type="checkbox"/> Yard Work                       | <input type="checkbox"/> Running: How long before an increase in pain? ____ mins / ____ hrs  |
| <input type="checkbox"/> Up / Down Stairs                | <input type="checkbox"/> Difficulty falling asleep: Sleep position: _____                    |
| <input type="checkbox"/> Lifting (please list):<br>_____ | <input type="checkbox"/> Awakened from sleep ____ times per night: Sleep position: _____     |
|  | <input type="checkbox"/> Other: _____  |

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

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Physical Therapy     | <input type="checkbox"/> Cardiologist              | <input type="checkbox"/> Lab (Bloodwork) | <input type="checkbox"/> Pulmonologist          |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> OB / Gynecologist         | <input type="checkbox"/> X-Rays          | <input type="checkbox"/> Hospitalization: _____ |
| <input type="checkbox"/> Massage Therapy      | <input type="checkbox"/> Sports Medicine Physician | <input type="checkbox"/> CT Scan         | <input type="checkbox"/> Other: _____           |
| <input type="checkbox"/> Chiropractor         | <input type="checkbox"/> Orthopedist               | <input type="checkbox"/> MRI             |   |
| <input type="checkbox"/> Podiatrist           | <input type="checkbox"/> Neurologist               | <input type="checkbox"/> EMG/NCV         |   |
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> ER Care                   | <input type="checkbox"/> Myelogram       |   |
|   |  | <input type="checkbox"/> Arthrogram      |   |

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

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Asthma, Bronchitis / Emphysema    | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Bowel / Bladder Problems      | <input type="checkbox"/> Leg / Foot / Ankle Injury / Surgery    |
| <input type="checkbox"/> Chest Pain                        | <input type="checkbox"/> Cancer / Chemo / Radiation  | <input type="checkbox"/> General Weakness              | <input type="checkbox"/> Knee Injury / Surgery                  |
| <input type="checkbox"/> Shortness of Breath               | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Weight Loss / Energy Loss     | <input type="checkbox"/> Medication Allergies: _____            |
| <input type="checkbox"/> Coronary (Heart) Disease / Angina | <input type="checkbox"/> Osteoporosis                | <input type="checkbox"/> Hernia                        | <input type="checkbox"/> Foods Allergies: _____                 |
| <input type="checkbox"/> Pacemaker                         | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Varicose Veins                | <input type="checkbox"/> Allergy to Tape                        |
| <input type="checkbox"/> High Blood Pressure               | <input type="checkbox"/> Sleeping Difficulty         | <input type="checkbox"/> Currently Pregnant            | <input type="checkbox"/> Allergy to Beeswax                     |
| <input type="checkbox"/> Heart Attack/Surgery              | <input type="checkbox"/> Anxiety / Depression        | <input type="checkbox"/> Use Tobacco (currently)       | <input type="checkbox"/> Allergy to Lanolin                     |
| <input type="checkbox"/> Stroke / TIA                      | <input type="checkbox"/> Memory Loss / Confusion     | <input type="checkbox"/> Pins / Metal Implants         | <input type="checkbox"/> Other Allergies: _____                 |
| <input type="checkbox"/> Congestive Heart Disease          | <input type="checkbox"/> Depression                  | <input type="checkbox"/> Joint Replacement Surgery     |   |
| <input type="checkbox"/> Blood Clot / Emboli               | <input type="checkbox"/> Psychiatric Treatment       | <input type="checkbox"/> Neck Injury / Surgery         | <b>History of Falls</b>   |
| <input type="checkbox"/> Epilepsy / Seizures               | <input type="checkbox"/> Severe / Frequent Headaches | <input type="checkbox"/> Shoulder Injury / Surgery     | <input type="checkbox"/> One Fall in Past Year                  |
| <input type="checkbox"/> Thyroid Disease / Goiter          | <input type="checkbox"/> Easily Bleed / Bruise       | <input type="checkbox"/> Elbow / Hand Injury / Surgery | <input type="checkbox"/> 2+ Falls in Past Year                  |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Numbness / Tingling         | <input type="checkbox"/> Back Injury / Surgery         | <input type="checkbox"/> Injury Related to a Fall (list): _____ |
| <input type="checkbox"/> Spitting Up Blood                 | <input type="checkbox"/> Dizziness / Fainting        | <input type="checkbox"/> Hip Injury / Surgery          |   |
| <input type="checkbox"/> Infectious Disease                | <input type="checkbox"/> Vision / Hearing Problems   |  |   |



**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**

Phone:

Fax: **(425) 831-3071**

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**