

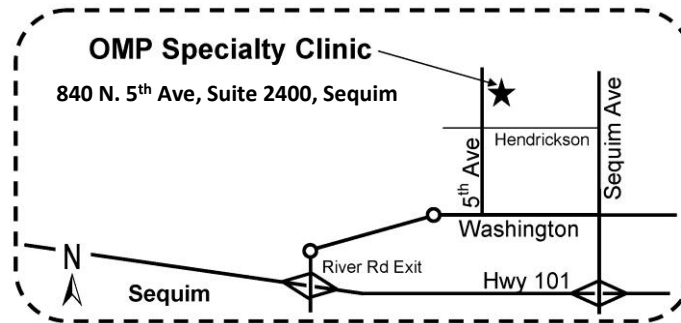
## Cardiology Appointment Reminder

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Appointment Address: **840 N. 5th Avenue, Suite 2400, Sequim**  
 Appointment Date: \_\_\_\_\_ Check In Time: \_\_\_\_\_  
 Provider:  Dr. Pan  Dr. Urnes  Tracy Zaher-Lee, ARNP

### Please do the following:

- **Fill out all of the enclosed forms.**
- **Bring the completed forms** to your appointment.
- **Bring your insurance cards, photo ID** and any **Advanced Healthcare Directive** you may have (IE. POLST form, Durable Power of Attorney for Healthcare, etc) to your appointment.
- **Bring any medications** you are currently taking.
- Please contact us at (360) 565-0500 if you need to reschedule or cancel your appointment.

### Directions:



#### If you are coming from Port Angeles:

1. Follow US-101 E
2. Take the River Rd exit
3. Turn LEFT onto River Rd.
4. Turn RIGHT onto Washington St.
5. At the traffic circle, continue STRAIGHT to stay on Washington St
6. At SECOND light turn LEFT onto 5<sup>th</sup> Ave
7. At light continue STRAIGHT on 5<sup>th</sup> Ave  
OMP Medical Services Building will be the on the RIGHT

#### If you are coming from East of Sequim:

1. Head NORTHWEST on US-101 W
2. Take the Sequim Ave exit
3. Turn RIGHT onto Sequim Ave
4. Turn LEFT onto Washington St.
5. Turn RIGHT onto 5<sup>th</sup> Ave
6. At light continue STRAIGHT on 5<sup>th</sup> Ave  
OMP Medical Services Building will be the on the RIGHT

**Thank you for choosing OMP Specialty Clinic!**



# Registration and Update Form (Confidential)



- Please complete all > **Required sections** of this form then
- Provide an **Insurance Card** and **Photo ID** for copying
- If you have any questions or concerns, please ask for assistance. We will be happy to help.

## > Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Mark the best)  Home: \_\_\_\_\_  Work: \_\_\_\_\_

Mobile: \_\_\_\_\_  Message: \_\_\_\_\_

Aliases / Nick Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

## > General Needs Interpreter If yes; Language: \_\_\_\_\_ Religion: \_\_\_\_\_

**Marital Status:**  Married  Single  Divorced  Widowed  Legally Separated

**Ethnicity:**  Hispanic  American Indian/Alaskan Native  Asian  Black/African American

Native Hawaiian/Pacific Islander  White/Caucasian  Other: \_\_\_\_\_

Employer: \_\_\_\_\_ Employment Status:  Part Time  Full Time

Never Employed  Not Employed  Active Military Duty  Disabled  Retired  Self Employed

Student Full Time  Student Part Time

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Primary Care Doctor (Doctor, Nurse Practitioner, Physicians Assistant, etc.)

Dr. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Patient Emergency Contacts-At least 1 immediate family member

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Financially Responsible Party (Guarantor) (Complete if Guarantor is the parent or anyone other than the patient)

Guarantor Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employment Status:  Part Time  Full Time

Never Employed  Not Employed  Active Military Duty  Disabled  Retired  Self Employed

Student Full Time  Student Part Time

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

## > Coverage Information

**Primary Insurance:** \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## > Advanced Directives Do you have any Advanced Directives? Yes No





## Review of Systems

(Please complete the following by checking Yes or No)

**Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

General	YES	NO
Fever		
Chills		
Weight loss		
Malaise/Fatigue		
Sweating (diaphoresis)		
Weakness		

Gastrointestinal	YES	NO
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Black stools (melena)		

Skin	YES	NO
Rash		
Itching		

Genitourinary	YES	NO
Painful urination (dysuria)		
Urgency		
Frequency		
Blood in urine (hematuria)		
Flank pain		

HENT	YES	NO
Headaches		
Hearing loss		
Ringing in ears (tinnitus)		
Ear pain		
Ear discharge		
Nosebleeds		
Congestion		
Upper airway wheezing (stridor)		
Sore throat		

Musculoskeletal	YES	NO
Muscle pain (myalgia's)		
Neck pain		
Back pain		
Joint pain		
Falls		

Eyes	YES	NO
Blurred vision		
Double vision		
Light sensitivity (Photophobia)		
Eye pain		
Eye discharge		
Eye redness		

Endo/Heme/Aller	YES	NO
Easy bruise/bleed		
Environmental allergies		
Excessive thirst (polydipsia)		

Cardiovascular	YES	NO
Chest pain		
Palpitations		
Shortness of breath laying down (orthopnea)		
Pain in limbs (claudication)		
Leg swelling		
Shortness of breath at night (PND)		

Neurological	YES	NO
Dizziness		
Tingling		
Tremor		
Loss of feeling (sensory change)		
Speech change		
Focal weakness		
Seizures		
Loss of consciousness (LOC)		

Respiratory	YES	NO
Cough		
Coughing up blood (hemoptysis)		
Sputum production		
Shortness of breath		
Wheezing		

Psychiatric	YES	NO
Depression		
Suicidal ideas		
Substance abuse		
Hallucinations		
Nervous/Anxious		
Insomnia		
Memory loss		

**Other:** \_\_\_\_\_

Contraception: YES \_\_\_\_\_ NO \_\_\_\_\_ Type: \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

Vaginal Deliveries: # \_\_\_\_\_ C-Section: # \_\_\_\_\_

Miscarriages / Abortions # \_\_\_\_\_



PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION



PATIENT INFORMATION

Patient Name (printed): Previous Name(s):

Date of Birth: Daytime Telephone Number:

INFORMATION TO BE RELEASED FROM:

I hereby authorize Olympic Medical Physicians Clinics to release the following information contained in my medical record and/or information regarding my medical care or condition as described in detail below.

INFORMATION TO BE RELEASED TO:

Name:

Relationship: Phone Number:

Name:

Relationship: Phone Number:

Name:

Relationship: Phone Number:

GENERAL INFORMATION TO BE RELEASED

- You may release test results and appointment information to the above named person(s)
You may discuss my medical condition(s) and/or current treatment with the above named person(s)

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

- Drug and Alcohol Abuse/Treatment
Mental Health/Psychiatric Disorders
HIV/AIDS Virus
Sexually Transmitted Diseases

CONSENT TO DISCLOSE

By my signature below I indicate that I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

This authorization will be valid until:

Date Signature of patient or representative Relationship to patient

FOR FACILITY USE ONLY

Date Received: Date Information Released: Chart #:
Person/Department Sending Records:
Faxed Mailed Picked Up: Other:







# Financial Assistance Plain Language Summary

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Olympic Medical Center is committed to serving all patients, including those who lack health insurance coverage and who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. Olympic Medical Center's Financial Assistance Program provides financial assistance for qualifying patients who need help paying for emergency or medically necessary care they receive in an Olympic Medical Center facility or by an Olympic Medical Center provider.

## **Who is eligible for Financial Assistance and what are the requirements?**

The program helps uninsured or underinsured patients who need help paying for all or part of their medical care. Patients are eligible for Financial Assistance when their Family Income is at or below 300% of the Federal Poverty Guidelines (FPG). Evaluation of other criteria may be required. Patients should consult with a Patient Financial Service Representative at 360-417-7111 to determine eligibility and for assistance applying. Patients who have experienced a catastrophic event may be eligible under special circumstances, regardless of household income.

## **What does the program cover?**

The Financial Assistance Program covers medically necessary care provided at an Olympic Medical Center facility or by an Olympic Medical Center provider.

## **Is there language assistance?**

Interpreters are available to you at no cost. The Financial Assistance application, policy, and this policy summary may be available in your language. For more information please call 360-417-7111.

## **How do I apply?**

For a free copy of the entire Financial Assistance Policy and/or an Application for Financial Assistance:

- Visit [www.olympicmedical.org](http://www.olympicmedical.org), then go to Patients & Visitors, Billing & Financial Services
- Visit the Patient Financial Services Department at 519 S Peabody, Port Angeles, WA 98362. Office hours are Monday-Friday 8:00 AM to 4:30 PM.
- Send a request by mail to: Olympic Medical Center, 519 S Peabody, Port Angeles, WA 98362
- Call Patient Financial Services at (360) 417-7111 or (800) 854-2844

Please mail the completed applications, including all required documentation and information specified in the application instructions to:

Olympic Medical Center, 519 S Peabody St., Port Angeles, WA 98362

We are able to process submitted applications only once they are complete, and will determine whether you are eligible according to the Olympic Medical Center Financial Assistance Policy. We will not consider incomplete applications, but will notify applicants and provide an opportunity to send the missing documentation or information by the required deadline.

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## **For additional information, please contact Patient Financial Services:**

### **Phone:**

(360) 417-7111  
(800) 854-2844

### **In Person:**

519 S Peabody St.  
Port Angeles  
Monday - Friday  
8:00am to 4:30pm

### **Mail:**

939 Caroline St.  
Port Angeles, WA 98362



## Financial Assistance Sliding Scale 2017

<b>Gross Monthly Income</b>					
<b>Family Size</b>	<b>100% Discount (100% FPG)</b>	<b>80% Discount (125% FPG)</b>	<b>60% Discount (150% FPG)</b>	<b>45% Discount (200% FPG)</b>	<b>30% Discount (300% FPG)</b>
1	0-1,005	1,006-1,257	1,258 - 1,508	1,509 - 2,010	2,011 - 3,015
2	0-1,354	1,355-1,692	1,693 - 2,030	2,031-2,708	2,709 - 4,060
3	0-1,702	1,703-2,128	2,129 - 2,553	2,554 - 3,404	3,405 - 5,105
4	0-2,050	2,051-2,563	2,564 - 3,075	3,076 - 4,100	4,101 - 6,150
5	0-2,399	2,400 - 2,998	2,999 - 3,598	3,599 - 4,797	4,798 - 7,195
6	0-2,747	2,748 -3,434	3,435 - 4,120	4,121 - 5,494	5,495 - 8,240
7	0-3,095	3,096 - 3,869	3,870 - 4,643	4,644 - 6,190	6,191 - 9,285
8	0-3,444	3,445 - 4,305	4,306 - 5,165	5,166 - 6,887	6,888 - 10,330

<b>Gross Annual Income</b>					
<b>Family Size</b>	<b>100% Discount (100% FPG)</b>	<b>80% Discount (125% FPG)</b>	<b>60% Discount (150% FPG)</b>	<b>45% Discount (200% FPG)</b>	<b>30% Discount (300% FPG)</b>
1	0-12,060	12,061-15,075	15,076-18,090	18,091-24,120	24,121-36,180
2	0-16,240	16,241-20,300	20,301-24,360	24,361-32,480	32,481-48,720
3	0-20,420	20,421-25,525	25,526-30,630	30,631-40,840	40,841-61,260
4	0-24,600	24,601-30,750	30,751-36,900	36,901-49,200	49,201-73,800
5	0-28,780	28,781-35,975	35,976-43,170	43,171-57,560	57,561-86,340
6	0-32,960	32,961-41,200	41,201-49,440	49,441-65,920	65,921-98,880
7	0-37,140	37,141-46,425	46,426-55,710	55,711-74,280	74,281-111,420
8	0-41,320	41,321-51,650	51,651-61,980	61,981-82,640	82,641-123,960

Due to yearly updates to this information, there may be a more recent version.  
 The latest version will be posted on our website:  
[www.olympicmedical.org](http://www.olympicmedical.org) then go to Patients & Visitors, Billing & Financial Services