OLYMPIC MEDICAL PHYSICIANS
Primary Care Clinic

433 E. 8th St., Port Angeles, WA 98362 ♦ (360) 565-0999 ♦ Fax: (360) 565-7635
907 Georgiana St., Port Angeles, WA 98362 ♦ (360) 565-0999 ♦ Fax (360) 565-0851
800 N. 5th Avenue, Suite 101, Sequim, WA 98382 ♦ (360) 565-0999 ♦ Fax: (360) 582-4221

Appointment Reminder

Patient Name: _____ Date of Birth: _____

Appointment Address: **907 Georgiana St., Port Angeles, WA 98362**

Appointment Date: _____ Check In Time: _____

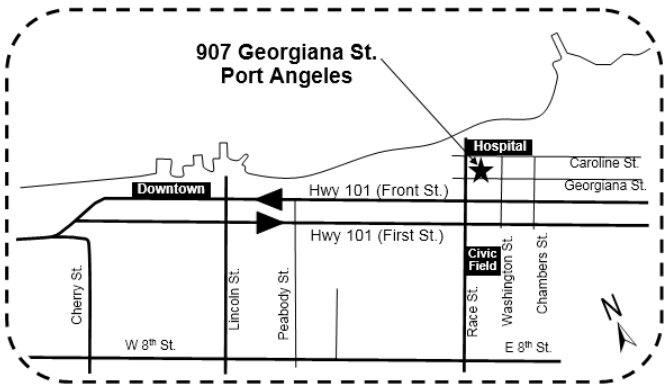
Provider: _____

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 (i.e. POLST form, Durable Power of Attorney for Healthcare, etc.) to your appointment.
- Please contact us at (360) 565-0999 if you need to reschedule or cancel your appointment.
- **The above time has been reserved especially for you. If you are unable to use this appointment, please give us 24 hour notice.**
- **If you do not confirm your new patient appointment within 24 hours prior to the appointment, it will be cancelled.**

Directions:

Please note,
Your appointment is in the new medical office building.



If you are coming from West of Port Angeles:

1. Follow US-101 E
2. Slight RIGHT onto Lauridsen Blvd
3. Turn LEFT onto Race St.
4. Turn RIGHT onto Georgiana St.
   our office is in the medical office building on the left.

If you are coming from Sequim:

1. Head NORTHWEST on Front St. toward Washington St.
2. Turn RIGHT onto Washington St.
3. After 1½ blocks turn LEFT into the parking lot of the new medical office building.

Thank you for choosing OMP Primary Care Clinic!

Patient History

PLEASE PRINT This information becomes part of your confidential medical record

OLYMPIC MEDICAL PHYSICIANS

Name:_____ Date of Birth_____

Primary Care Provider:_____ Referring Provider_____

Presenting Problem: Please describe the specific problems or questions you would like to have addressed

Medications (include supplements and over the counter drugs)

Name	Dose	Frequency	Purpose

Pharmacy/ Local: Mail Order:

Allergies

Agent	Reaction

Past Surgical History

Type of surgery	Date	Surgeon/City	Reason

Family History

Relationship	Age	Medical Conditions / Cause of death
Mother	❑ deceased	
Father	❑ deceased	
Brother(s) #____	❑ deceased	
Sisters(s) #____	❑ deceased	
Children #____	❑ deceased	

Social History / Habits

❑ Married ❑ Single ❑ Divorced **Children:** ❑ No ❑ Yes if yes: Number of Children:_____

Occupation:_____ **Retired:**_____

Smoking/Tobacco ❑ current ❑ quit ❑ never

year started: _____ → year quit: _____ packs/year:

cigarettes	yes / no	amt:	
cigars	yes / no	amt:	
smokeless	yes / no	amt:	
Alcohol	yes / no	Drinks/day	
Caffeine use	yes / no	Type	cups/day
Exercise	yes / no	Type	amount

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		

Skin	YES	NO
Rash		
Itching		

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

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

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

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

Other:

Contraception: YES_____ NO _____ Type: _____

Last Menstrual Period: _____

Vaginal Deliveries: #_____ C-Section: #_____

Miscarriages / Abortions #_____

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

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

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

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

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

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

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.

OLYMPIC MEDICAL CENTER

➢ 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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Olympic Medical Physicians
433 E. 8th St. ♦ Port Angeles, WA 98362 ♦ (360) 565-7670
Fax: (360) 565-7672

PATIENT INFORMATION

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

Date of Birth:_____ Daytime Telephone Number:_____

SEND INFORMATION TO: (please be specific)

Name: **Olympic Medical Physicians**

Address: **433 E. 8th St.**

City: **Port Angeles** State: **WA** Zip: **98362**

Phone #: **(360) 565-7670** Fax #: **(360) 565-7672**

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Fax #:_____

PURPOSE OF DISCLOSURE

❑ Transfer of Care ❑ Self ❑ Specialist ❑ Other _____(must complete)

INFORMATION TO BE DISCLOSED

❑ Medical Records from last two years

❑ Limited Health Information or Documentation Dates of Service:_____

❑ Complete Medical Chart Contents

❑ Other_____ Expiration Date (or event)_____

FORMAT ❑ Paper ❑ Electronic (MyChart)

CONSENT TO DISCLOSE

If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. This form may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA of 1996.

Date	Signature of patient or representative	Relationship to patient

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):

_____ HIV/AIDS Virus _____ Mental Health/Psychiatric Disorders

_____ Sexually Transmitted Diseases _____ Drug, Alcohol Abuse/Treatment

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 ❑ MyChart ❑ Picked Up:_____ ❑ Other:_____

OLYMPIC
MEDICAL PHYSICIANS

PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION

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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:_____

OLYMPIC MEDICAL CENTER

Financial Assistance
Plain Language Summary

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, 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.

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

OLYMPIC MEDICAL CENTER

Financial Assistance Sliding Scale 2017

Gross Monthly Income					
Family Size	**100% Discount (100% FPG)**	**80% Discount (125% FPG)**	**60% Discount (150% FPG)**	**45% Discount (200% FPG)**	**30% Discount (300% FPG)**
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

Gross Annual Income					
Family Size	**100% Discount (100% FPG)**	**80% Discount (125% FPG)**	**60% Discount (150% FPG)**	**45% Discount (200% FPG)**	**30% Discount (300% FPG)**
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 then go to Patients & Visitors, Billing & Financial Services