



Patient History

PLEASE PRINT This information becomes part of your confidential medical record

Name	DOB
Occupation (previous if retired)	Marital Status
Primary Doctor	

Presenting Problem Please describe the specific problem you would like to have addressed today:

Past Surgeries

Chronic Medical Conditions

Medications	(include supplements and over the counter drugs)		<input type="checkbox"/> Not taking Medications
Name of Medication	Dosage	How often?	What is it for?

Pharmacy

Allergies		<input type="checkbox"/> No known allergies
Agent	Reaction	

Tobacco and Alcohol

Cigarettes: Never used Year Started: _____ Year Quit: _____
E-cigarettes: Never used Year Started: _____ Year Quit: _____
Cigars: Never used Year Started: _____ Year Quit: _____
Chew/snuff: Never used Year Started: _____ Year Quit: _____
Alcohol: yes / no Drinks/day

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



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

Do I qualify?

Based on your income and family size, you may qualify for a discount of 30-100% of your bill.

In some cases, we'll evaluate criteria other than income. For example, if you experience a catastrophic event, you may qualify regardless of income.

Examples:

Individual with
\$18,000 income
= 60% discount



Couple with
\$48,000 income
= 30% discount



Family of four with
\$24,000 income
= 100% discount



For a full list of family incomes, family sizes, and discounts, see the next page.

What does the Program cover?

The Program covers medically necessary care provided by us or by one of our providers.

How do I apply?

Consult a Patient Financial Service Representative at 360-417-7111 for help applying. For a free copy of the entire Financial Assistance Policy and an application:

- **Online:** www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services
- **In Person:** 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
- **Mail:** Mail a request to Olympic Medical Center, 519 S Peabody, Port Angeles, WA 98362
- **Telephone:** Call Patient Financial Services at (360) 417-7111 or (800) 854-2844

Mail or bring your completed application and required documentation to Olympic Medical Center, 519 S Peabody St., Port Angeles, WA 98362. We process submitted applications only once they are complete. If your application is not complete, we will notify you and provide an opportunity to send the missing documentation or information.

Olympic Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish
Español

Olympic Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-360-417-7000 TTY: 1-360-417-8686

Chinese
繁體中文

Olympic Medical Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-360-417-7000 TTY: 1-360-417-8686



Financial Assistance Sliding Scale 2018

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 - 1012	1,013 - 1,265	1,266 - 1,518	1,519 - 2,023	2,024 - 3,035
2	0 - 1372	1,373 - 1,715	1,716 - 2,058	2,059 - 2,743	2,744 - 4,115
3	0 - 1732	1,733 - 2,165	2,166 - 2,598	2,599 - 3,463	3,464 - 5,195
4	0 - 2092	2,093 - 2,615	2,616 - 3,138	3,139 - 4,183	4,184 - 6,275
5	0 - 2452	2,453 - 3,065	3,066 - 3,678	3,679 - 4,903	4,904 - 7,355
6	0 - 2812	2,813 - 3,515	3,516 - 4,218	4,219 - 5,623	5,624 - 8,435
7	0 - 3172	3,173 - 3,965	3,966 - 4,758	4,759 - 6,343	6,344 - 9,515
8	0 - 3532	3,533 - 4,415	4,416 - 5,298	5,299 - 7,063	7,064 - 10,595

Based on Annual Gross 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 - 12,140	12,141 - 15,175	15,176 - 18,210	18,211 - 24,280	24,281 - 36,420
2	0 - 16,460	16,461 - 20,575	20,576 - 24,690	24,691 - 32,920	32,921 - 49,380
3	0 - 20,780	20,781 - 25,975	25,976 - 31,170	31,171 - 41,560	41,561 - 62,340
4	0 - 25,100	25,101 - 31,375	31,376 - 37,650	37,651 - 50,200	50,201 - 75,300
5	0 - 29,420	29,421 - 36,775	36,776 - 44,130	44,131 - 58,840	58,841 - 88,260
6	0 - 33,740	33,741 - 42,175	42,176 - 50,610	50,611 - 67,480	67,481 - 101,220
7	0 - 38,060	38,061 - 47,575	47,576 - 57,090	57,091 - 76,120	76,121 - 114,180
8	0 - 42,380	42,381 - 52,975	52,976 - 63,570	63,571 - 84,760	84,761 - 127,140

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