OLYMPIC
MEDICAL PHYSICIANS
Walk-In Clinic

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)** ❑ **Not taking Medications**

Name of Medication	Dosage	How often?	What is it for?

Pharmacy

Allergies ❑ **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.

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

OLYMPIC
MEDICAL PHYSICIANS

PERSONAL RELEASE OF PROTECTED HEALTH INFORMATION

999

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. Patients must fill out an application to apply and must meet the eligibility requirements listed below to qualify.

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 2016

Based on Monthly Gross Income

Family Size	100% Discount	80% Discount	60% Discount	45% Discount	30% Discount
1	- 990	991 - 1,237	1,238 - 1,485	1,486 - 1,980	1,981 - 2,970
2	- 1,335	1,336 - 1,668	1,669 - 2,002	2,003 - 2,670	2,671 - 4,005
3	- 1,680	1,681 - 2,100	2,101 - 2,520	2,521 - 3,360	3,361 - 5,040
4	- 2,025	2,026 - 2,531	2,532 - 3,037	3,038 - 4,050	4,051 - 6,075
5	- 2,370	2,371 - 2,962	2,963 - 3,555	3,556 - 4,740	4,741 - 7,110
6	- 2,715	2,716 - 3,393	3,394 - 4,072	4,073 - 5,430	5,431 - 8,145
7	- 3,061	3,062 - 3,826	3,827 - 4,592	4,593 - 6,122	6,123 - 9,183
8	- 3,408	3,409 - 4,260	4,261 - 5,112	5,113 - 6,816	6,817 - 10,224

Based on Annual Gross Income

Family Size	100% Discount	80% Discount	60% Discount	45% Discount	30% Discount
1	- 11,880	11,881 - 14,850	14,851 - 17,820	17,821 - 23,760	23,761 - 35,640
2	- 16,020	16,021 - 20,025	20,026 - 24,030	24,031 - 32,040	32,041 - 48,060
3	- 20,160	20,161 - 25,200	25,201 - 30,240	30,241 - 40,320	40,321 - 60,480
4	- 24,300	24,301 - 30,375	30,376 - 36,450	36,451 - 48,600	48,601 - 72,900
5	- 28,440	28,441 - 35,550	35,551 - 42,660	42,661 - 56,880	56,881 - 85,320
6	- 32,580	32,581 - 40,725	40,726 - 48,870	48,871 - 65,160	65,161 - 97,740
7	- 36,730	36,731 - 45,913	45,914 - 55,095	55,096 - 73,460	73,461 - 110,190
8	- 40,890	40,891 - 51,113	51,114 - 61,335	61,336 - 81,780	81,781 - 122,670

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