SKYLINE
MEDICAL CLINIC

Patient Registration Form

Today's date:	PCP:	
Patient Information		
Patient's name:	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status:
List any other names you go by or have gone by:	Date of birth:	Gender:
Street address:	SSN:	Phone:
Mailing address:	City, state, zip code:	
Occupation:	Employer:	Employer phone:
Referred to clinic by: ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other:		
Other family members seen here:		

Insurance Information			
Please present your insurance card to the receptionist.			
Person responsible for bill:	Date of birth:	Address (if different):	Phone:
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone:
Primary insurance and claims address, if available:			Co-pay: $
Subscriber's name:		Subscriber's SSN:	Date of birth:
Patient's relationship to subscriber:	Policy number:	Group number:	
Secondary insurance and claims address, if available:			
Subscriber's name:		Subscriber's SSN:	Date of birth:
Patient's relationship to subscriber:	Policy number:	Group number:	

Emergency Contact	
Name of local friend or relative (not at same address):	Relationship to patient:
Phone:	Employer phone:

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Patient History Form

Today's date:	Patient name:
Date of birth:	Gender:
Current medical conditions (ex: Diabetes, heart disease, emphysema, cancer):	
Surgeries/hospitalizations/injuries:	
Allergies & reaction:	

Health History

Have you or a family member ever been diagnosed with the following?

	No	You	Family (list relation)		No	You	Family (list relation)
STD (list type)	❑	❑	❑ :	Liver disease	❑	❑	❑ :
Thyroid disease	❑	❑	❑ :	Bleeding disorders	❑	❑	❑ :
Heart disease	❑	❑	❑ :	Any hereditary illness	❑	❑	❑ :
Cancer (list type)	❑	❑	❑ :	Diabetes (list type)	❑	❑	❑ :
Stroke	❑	❑	❑ :	Blood clots	❑	❑	❑ :
High blood pressure	❑	❑	❑ :	Mental health issue	❑	❑	❑ :

List individuals who live with you (name and relation):

Have you ever smoked/used tobacco? ❑ Yes, currently ❑ Yes, but I quit ❑ No, never smoked/used tobacco

If you answered yes above, list starting age:	If you are a former smoker/user, list age you quit:

If you answered yes above, list how many cigarettes per day:

How many times in the past year have you had 5 (men) or 4 (women) drinks in one day:

Do you use drugs? ❑ Yes ❑ No If yes, what and how much/how often?

Are you experiencing any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Chills	❑	❑	Night sweats	❑	❑	Constipation
❑	❑	Fever	❑	❑	Fatigue/weakness	❑	❑	Hemoptysis (blood in sputum)
❑	❑	Back pain	❑	❑	Weight loss	❑	❑	Loss of appetite
❑	❑	Chest pain/palpitations	❑	❑	Abdominal pain	❑	❑	Nausea/vomiting/diarrhea
❑	❑	Lactation	❑	❑	Shortness of breath	❑	❑	Painful urination
❑	❑	Cough	❑	❑	Skin breakdown/would due to pressure/rash			

Family Planning

List past pregnancies/births:

Are you planning on being pregnant within the next year? ❑ Yes ❑No

Do you use birth control? ❑ Yes ❑No	If yes, list type(s) of birth control you use:

Are you satisfied with your current birth control? ❑ Yes ❑ No

Nutrition & Physical Activity
What do you think of your body size?
How would you describe your eating at home?
List type, frequency and duration of any physical activity you perform:

Social Factors	
Over the past two weeks, how often have you been bothered by any of the following problems? *Little interest or pleasure in doing things.* 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day *Feeling, down, depressed, or hopeless.* 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day	
Do you feel safe at home? ❑ Yes ❑ No ❑ N/A	Do you have emotional support available? ❑ Yes ❑ No
Are you chronically or terminally ill with frequent medical care visits? ❑ Yes ❑ No	
Are you currently employed? ❑ Yes ❑ No	If yes, list your occupation:
Do you have any financial concerns?	
List any circumstances that cause you major stress:	

Medication List
Preferred pharmacy (name and location):
List any medications (include dose):

Other Medical Providers
List any other medical providers you see:

Skyline Medical Clinic - Patient Request for Confidential Communication

State and federal privacy laws prevent Skyline Medical Clinic staff from providing your medical information to anyone you have not approved. If you would like to authorize Skyline Medical Clinic staff to discuss your protected health information with your family and/or friends, please complete this form.

Skyline Medical Clinic staff will not release a copy of your medical record to any person without your specific written consent/request. If you would like us to provide you or your family with copies of your medical records, please request a Release of Information Form from your medical assistant or the receptionist.

1. If family members inquire about your health, would you like Skyline Medical Clinic staff to provide information related to your condition?

   ☐ *Yes, I would like Skyline Medical Clinic staff to share the following information with my family:*
      - ☐ *Diagnosis, test results, plans and disposition.*
      - ☐ *Diagnosis only.*
      - ☐ *General condition information only.*

   ☐ *No, please do not share my protected health information with any of my family members.*

2. If you checked "Yes" above, please list the names of the family members you authorize our staff to speak with regarding your designated Protected Health Information with (please use back page to list more names):

Name of Family Member (please print):	**Relationship to you:**

Patient Signature:	**Date:**
Staff Signature:	**Date:**

Revised 3/2018

Patient ID label

SKYLINE HOSPITAL

Skyline Family Medicine - Consent for Release of Information

Patient Name (legible, legal name):		Maiden/nickname/other names:
Mailing Address:		Date of birth:
City, state, zip code:		Phone:
Please OBTAIN information from:	**Please SEND my information to:**	
Hospital, Clinic, Provider Name:	Name of Person, Clinic or Hospital:	
Address:	Address:	
City, State, Zip Code:	City, state, zip code:	
❑ Please call when records are ready for pick up.* ❑ Please mail records.* ❑ Please fax records.*	Fax To This Number:	Phone Number:

I authorize above named Hospital, Clinic or Provider to release the following protected health information as noted above:
Specific treatment date(s) or admission(s) or date range: _____
Specific information as listed below:

❑ X-ray CD
❑ X-ray report
❑ Operative report
❑ Laboratory report
❑ History & Physical report
❑ Discharge summary
❑ Emergency report
❑ Progress note
❑ Other: _____

Purpose of this Release request: _____

I understand that certain information in these records cannot be released without specific authorization due to Federal and/or State law. **By initialing below**, I specifically authorize the release of the following confidential and protected health information:

_____ HIV test and/or other sexually transmitted disease test results and related information, including documentation of high-risk behavior.
_____ Drug and/or alcohol abuse, diagnosis, treatment.
_____ Genetic testing results and related information.
_____ Mental Illness/Psychiatric treatment information.

I give my specific authorization for these records to be released. My consent may be revoked at any time by written notification to Privacy Officer, Skyline Hospital, PO Box 99, White Salmon WA 98672. The only exception is when the action has already occurred as initially instructed in this Consent. Any care provided by Skyline Hospital will not be affected if you do not sign this form.

Patient signature:	Parent/Legal Guardian signature (if applicable):
Printed Name:	☐ Yes - Guardianship Paperwork on file. ☐ No - **Do not release** pending paperwork provided.
Date:	**Expiration Date of this Authorization/ROI:**
Please allow **15 days** for completion of your records request (RCW 70.02.080). There is **no charge** for records provided to patients or physicians, clinics and hospitals for **continuity of patient care**. **Skyline Family Medicine ROI P: 509-637-2810 | F: 509-493-1368**	
For official use only: Sent via: ❑ Mail ❑ Fax ❑ Picked up (by: _____) Legal ID checked: _____ ROI copy given: _____ Date records sent: _____ Release sent/processed by: _____	

SKYLINE HOSPITAL

CONDITIONS OF SERVICES

OUTPATIENT

FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Skyline Hospital for hospital benefits otherwise payable to me but not to exceed the hospital's regular charge for this period of service. I understand I will receive a statement each month if my account has an outstanding balance. I further understand the hospital cannot accept responsibility for collecting my insurance claim or for negotiating a settlement on a disputed claim: and that I am responsible for the timely payment of my account, and for all delinquency charges resulting from a failure to pay that account timely. Should the account be referred to an attorney or collection partner for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

I further authorize the Hospital to make such inquiry as it determines necessary to confirm my coverage and my financial responsibility, from any third party payors or financial references I may have named, and I hereby authorize those payors and/or references to release such information to the Hospital.

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she is hereby individually obligated to pay the account, as well as obligating the patient, and the hospital may look to either or both for payment. Any balance on the account that is the patient or guarantor's responsibility could be combined with other accounts and a payment plan established, per hospital board policy.

FINANCIAL ASSISTANCE

Financial Assistance is a way to help low income people and families pay for medical services and covers necessary or emergency hospital care. Skyline Hospital provides Financial Assistance to those patients who have exhausted any third-party sources, including Medicare and Medicaid, and whose income is equal to or below 200% of the federal poverty standards as established in Financial Assistance Policy. An Application can be obtained at the Patient Services Department.

FOR MEDICARE PATIENTS ONLY

Medicare does not cover self-administered medications for Out Patient Services. You will be responsible for charges of self-administered medications.

I certify that the information given by me in applying for payment under the appropriate titles of the Social Security Act of HB-89-97 is correct. I authorize release of any information to act on this request. I request that this authorization apply to the anticipated period of treatment but not to exceed one (1) year.

MEDICAL CONSENT

The undersigned authorizes and consents to any medical treatment, release of medical information, x-ray examination, laboratory procedure (these tests may include HIV testing) or other hospital service that may be deemed advisable or necessary by attending or consulting service physicians. The patient is under the care of his physicians and the hospital shall not be held liable for any act or omission in following said physicians orders. The undersigned recognizes that many doctors of medicine, including radiologists, pathologists, and anesthetists, are independent contractors and not employees of the hospital and may bill the patient separately. The undersigned authorizes and consents for Skyline Hospital to take identification photos and/or medical photos.

RELEASE OF INFORMATION

The Hospital may provide patient demographic information to Press Ganey Assoc., Inc. for the purpose of conducting Customer Satisfaction Surveys.

The Hospital may disclose to third party payors, or their collection partners, billing affiliates and other health care providers the patients record and any other information needed relating to my treatment and/or admission.

LOST OR STOLEN ITEMS

It is the policy of Skyline Hospital that patients assume responsibility for the care of their own property unless it is submitted for safe keeping.

PATIENT RIGHTS

I acknowledge that I have received the Patient Rights and Responsibilities. (Please Initial) _____

MEDICAL SGREENING EXAMINATION AND NECESSARY STABILIZING TREATMENT WILL BE PROVIDED EVEN IF THE PRESENTING PATIENT CANNOT PAY

_____ _____

Signature Name (please print)

_____ _____

Signature of Person Authorized to Consent for Patient Relationship to Patient

_____

Witness Date Time