



SKYLINE HEALTH MEDICAL CLINIC

Patient Demographic Information

| | | |
|----------------|--------|---------------------|
| Last: | First: | Middle: |
| Date of Birth: | Sex: | Preferred Language: |

| | | |
|---|---|--|
| Race: <input type="radio"/> Caucasian <input type="radio"/> African American <input type="radio"/> Asian <input type="radio"/> Native American <input type="radio"/> Decline <input type="radio"/> Other: | Ethnicities: <input type="radio"/> Hispanic or Latino <input type="radio"/> Decline <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Other: | Marital Status: <input type="radio"/> Single <input type="radio"/> Widow/Widower <input type="radio"/> Married <input type="radio"/> Other Relationship |
|---|---|--|

| | | |
|----------|-------------------|-----------|
| Address: | Apt/Suite/PO BOX: | |
| City: | State: | Zip Code: |

| | | |
|---------------|--------------------|--------|
| Phone Number: | Alternative Phone: | Email: |
|---------------|--------------------|--------|

| | | |
|--------------------|-----------|--------------------|
| Employment Status: | Employer: | Work Phone Number: |
|--------------------|-----------|--------------------|

| | | | |
|-----------------------|---------------|---------------|------|
| Emergency Contact #1: | Phone Number: | Relationship: | DOB: |
| Emergency Contact #2: | Phone Number: | Relationship: | DOB: |
| Emergency Contact #3: | Phone Number: | Relationship: | DOB: |
| Emergency Contact #4: | Phone Number: | Relationship: | DOB: |

Guardian Information (Complete if under 18):

| | | | |
|--------------|----------|---------------|------|
| Parent Name: | Address: | Phone Number: | DOB: |
| Parent Name: | Address: | Phone Number: | DOB: |



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Patient History Form

| | |
|----------------|---------------|
| Today's Date: | Patient name: |
| Date of Birth: | Gender: |

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|--|
| Current medical conditions (ex: Diabetes, heart disease, emphysema, cancer): |
| Reason for today's visit: |

| | |
|--------------------------------------|------------------------|
| Surgeries/hospitalizations/injuries: | Primary Care Provider: |
|--------------------------------------|------------------------|

| |
|-----------------------|
| Allergies & reaction: |
|-----------------------|

Health History

| | | |
|--|---|--|
| Have you ever smoked/used tobacco? <input type="checkbox"/> Yes, currently <input type="checkbox"/> Yes, but I quit <input type="checkbox"/> 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: | | |

Are you experiencing any of the following?

| Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chills/fever | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain/palpitations | <input type="checkbox"/> | <input type="checkbox"/> | Urinary pain/leakage |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss | <input type="checkbox"/> | <input type="checkbox"/> | Cough/shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Sexual problem |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain/joint pain | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Skin breakdown/rash |

Medication List:

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

Other Medical Providers

List any other medical providers that you have seen within the past three (3) years:

Nutrition & Physical Activity

How would you describe your eating at home?

List type, frequency and duration of any physical activity you perform.

What do you think of your body size?

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

Social Factors

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?

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

Are you currently employed? | List your occupation:

Do you have any financial concerns?

In the last year, did you worry that your food would run out before you got money or food stamps to buy more? Yes or No

List any circumstances that cause you major stress:

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle)

Little interest or pleasure in doing things.

Feeling, down, depressed, or hopeless

0 = Not at all

0 = Not at all

1 = Some days

1 = Some days

2 = More than half the days

2 = More than half the days

3 = Nearly every day

3 = Nearly every day

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

Do you use marijuana, CBD, methamphetamine, cocaine or heroin? (Circle)

Medical Conditions - Has anyone in your family ever been diagnosed with any of the following?

| | | | |
|---------------------|------------------------|-----------------------|----------------|
| Thyroid disease | Diabetes | Mental health illness | Cancer (type): |
| Heart disease | Liver disease | Kidney problems | |
| Stroke | Bleeding disorders | STD (list type): | |
| High blood pressure | Any hereditary illness | | |



NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless, you direct us to do so, or unless the law authorizes or requires us to do so. You may see your record or get more information about it by contacting Skyline Health’s Medical Records Department.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Printed Patient Name

Signature of Patient or Authorized Representative

Date

Printed Name, if Signed on Behalf of Patient

Relationship to Patient

This form will be retained in your medical record.

MEDICAL RECORD NUMBER:



Skyline Health Medical Clinic - Patient Request for Confidential Communication

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

Skyline Health 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 Health Medical Clinic staff to provide information related to your condition?

- Yes, I would like Skyline Health 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: |
|---------------------------------------|----------------------|
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|---------------------------|--------------|
| Patient Signature: | Date: |
| Staff Witness: | Date: |

Revised 6/2020



**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. I request that this authorization apply to the anticipated period of treatment not to exceed one (1) year.

Skyline Medical Clinic includes a licensed behavioral health specialist as part of the care team that supports a variety of mental health, substance use, stress and lifestyle change related needs. The entire care team shares information to coordinate a patient's treatment.

RELEASE OF INFORMATION

The Hospital may use and disclose your PHI for our health care operations, which include internal administration, planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our practitioners and staff members. We may disclose PHI for our patient satisfaction survey process. We may disclose PHI to our Patient Advocate in order to resolve any complaints you may have and ensure that you have a comfortable visit with us. The Hospital may provide patient demographic information to Press Ganey Assoc., Inc. for the purpose of conducting Customer Satisfaction Surveys. The Hospital may utilize a Health Information Exchange (HIE) for Patient Records. The patient may opt out of this HIE at any time by written notice.

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, admission and billing and collecting monies due. The undersigned authorizes and consents to be called or text at the number(s) provided at registration by automatic dialing.

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

To be informed that a doctor of medicine or osteopathy may not be present in the hospital 24 hours per day, seven days a week, but that there is a doctor available on-call. I acknowledge that I have received the Patient Rights and Responsibilities. _____ (Please Initial)

MEDICAL SCREENING 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 _____