Olympia Multi-specialty Clinic

406A-Black Hills Lane SW
Olympia, WA 98502
(360) 754-1727 FAX (360) 754-1783

PATIENT INFORMATION (please print)

Patient's Name: _____
Last **First** **MI**

Address: _____
Street **City** **State** **Zip**

Sex: ☐ **Male** ☐ **Female** **Marital status:** ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Other** _____

Social Security #_____-_____-_____ **Date of Birth:** _____

Telephone: _____/ _____ /_____
Home **Work** **Cell**

Email Address: _____ **(Required under new healthcare laws)**
Please print clearly

Email Statements: ☐ **Yes** ☐ **No** **Portal Access** ☐ **Yes** ☐ **No**

Patient's Employer: _____**Occupation:** _____

Spouse's Name: _____ **Spouse's Employer:** _____

Telephone: _____/ _____
Home **Work**

IF PATIENT IS A MINOR (Under 18 Years)

Responsible Party: _____

Address: _____
Street **City** **State** **Zip**

Telephone: _____/ _____
Home **Work**

Relationship: _____ **Social Security #**_____-_____-_____ **Date of Birth:** _____

Employer's Name & Address: _____

REFERENCE: Relative or friend living at another address:

Name: _____**Relationship:** _____

Telephone: _____/ _____
Home **Work**

Whom may we thank for referring you? _____

PLEASE COMPLETE REVERSE SIDE

INSURANCE INFORMATION:

Primary Insurance: _____ **Subscriber ID# or SS#**_____-_____-_____

Group #_____ **Effective Date:** _____ **Relationship:** _____

Subscriber Name: _____ **Date of Birth:** _____

Secondary Insurance: _____ **Subscriber ID# or SS#** _____-_____-_____

Group #_____ **Effective Date:** _____ **Relationship:** _____

Subscriber Name: _____ **Date of Birth:** _____

FINANCIAL AGREEMENT, EXTENSION OF CREDIT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above. I understand that services provided may not be covered by my insurance carrier. I agree to be personally and financially responsible for payment in full of all fees and charges for such treatment, regardless of my insurance coverage and referral procedures. I agree to pay all charges for myself and members of my family shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing.

In accordance with the Federal Truth-in-Lending Act which requires us to give our patients information in connection with extension of credit, please be advised of the following policies which apply in this clinic. The responsible party agrees:

1. **To pay the doctor at the time treatment or service is received or by previous arrangements.**
2. **That if payments are extended beyond 60 days from the date of patient responsibility to pay 1% per month on the unpaid balance (annual rate of 12%) with a minimum charge of $1 per month.**
3. **To pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.**
4. **To a $50.00 charge for missed or cancelled appointments within 24 hours of the scheduled appointment time.**
5. **To a $100.00 charge for missed or cancelled procedures within 72 hours of the scheduled appointment time.**

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. A copy of this assignment is as valid as the original.

Signature of Responsible Person:_____**Date:**_____

OMNIBUS BUDGET RECONCILIATION ACT OF 1990 (OBRA '90') ADVANCE DIRECTIVES

Do you have a living will? ___yes ___no
Do you have a durable power of attorney for health care? ___yes ___no
If not, do you wish additional information? ___yes ___no
The existence or execution of a living will, durable power of attorney for health care, or other written advance directive is not a condition of receiving health care services and may not otherwise be used to discriminate an individual.

Signature:_____**Date:**_____

PAYMENTS OF BENEFITS – AUTHORIZATION

I authorize payment of medical benefits to the Olympia Multi-specialty Clinic for any services furnished me. I also authorize the release medical or other information necessary to process claims for these services provided.

Signature:_____**Date:**_____

AUTOMATED TELEPHONE SYSTEM – AUTHORIZATION

I authorize Olympia Multi-specialty Clinic to use an automated telephone system and to use my first name, the name of the treating physician, and the time and place of my scheduled appointment(s), for the limited purpose of notifying me of a pending appointment(s). I also authorize Olympia Multi-specialty Clinic to disclose to third parties who may answer my phone, limited protected health information regarding my pending appointment(s).

Signature:_____**Date:**_____

CONFIDENTIAL MESSAGES ON ANSWERING MACHINE OR VOICE MAIL - AUTHORIZATION

I authorize Olympia Multi-specialty Clinic to disclose protected health information on my answering machine or my voice mail.

Signature:_____**Date:**_____

ELECTRONIC MEDICATION HISTORY - AUTHORIZATION

I authorize Olympia Multi-specialty Clinic to obtain my medication history on my behalf.

Signature:_____**Date:**_____

Medical History Form

Date:_____ Account #_____

Name: _____ Birth Date:_____ Age:____ Sex:_____

Medications

Name	Dose	Times Taken	Prescribing Provider

Allergies

Name	What happened? (examples: rash, hives, nausea)

Symptoms that you have. Check all that apply.

General
- ☐ Fatigue
- ☐ Weight loss
- ☐ Fever
- ☐ Night Sweats

Blood
- ☐ Bruise easily
- ☐ Anemia
- ☐ Bleeding

Endocrine
- ☐ Feel cold often
- ☐ Feel hot often
- ☐ Sexual dysfunction

Lungs
- ☐ Short of breath
- ☐ Wheezing
- ☐ Cough

Skin
- ☐ Rash, hives
- ☐ Itching

Heart
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swollen legs, ankles
- ☐ Trouble breathing at night
- ☐ Fainting, blackouts
- ☐ Leg pain when walking

Gastrointestinal
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Trouble swallowing
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Rectal bleeding
- ☐ Rectal pain
- ☐ Jaundice

Urinary Tract
- ☐ Pain when urinating
- ☐ Difficulty Urinating
- ☐ Blood in Urine

Eyes/Ears/Nose
- ☐ Ringing in ears
- ☐ Poor vision
- ☐ Nasal congestion
- ☐ Snoring

Nervous System
- ☐ Headaches
- ☐ Seizures
- ☐ Numbness
- ☐ Loss of memory
- ☐ Weakness arm, leg

Bones/Joints
- ☐ Joint pain _____
- ☐ Back pain
- ☐ Muscle aches

Please continue on the backside of this form

Problems or Conditions that you have. Check all that apply.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart Attack
- ☐ Heart valve condition
- ☐ Irregular heart rhythm
- ☐ Heart stent
- ☐ Stroke
- ☐ Heart failure
- ☐ Blood clots
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Asthma
- ☐ COPD, emphysema
- ☐ Thyroid disease
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Ulcers
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Cancer _____
- ☐ Rheumatic fever
- ☐ Hepatitis
- ☐ Colon polyps
- ☐ Kidney infections
- ☐ Other _____
- ☐ Other _____

Family History

	Father	Mother	Brother	Brother	Sister	Sister
Age of Death						
Heart Attack						
Hypertension						
Heart Bypass						
Stroke						
Cancer						
Diabetes						
Colon Polyps						
Liver Disease						
Gallbladder						

Surgeries - Year

- ☐ Gallbladder _____
- ☐ Tonsils _____
- ☐ Appendix _____
- ☐ Heart Bypass_____
- ☐ Heart Valve _____
- ☐ Heart Stent
- ☐ Hysterectomy_____
- ☐ Ovaries _____
- ☐ Back _____
- ☐ Breast _____
- ☐ Knee _____
- ☐ Hip _____
- ☐ Other _____
- ☐ Other _____

Tobacco ☐Y ☐N

- ☐ Cigarettes _____packs/day
- ☐ Chewing tobacco
- ☐ Cigars _____number/day

Alcohol ☐Y ☐N

- ☐ Beer _____ per day
- ☐ Wine _____ glasses per day
- ☐ Liquor ____ ounces per day

Coffee ☐Y ☐N

- ☐ Caffeinated _____ cups per day
- ☐ Decaffeinated ____ cups per day

Routine Health Care - Date last

- ☐ Stool test for blood _____
- ☐ Mammogram _____
- ☐ PAP smear _____
- ☐ Chest X Ray _____
- ☐ Sigmoidoscopy _____
- ☐ Colonoscopy _____
- ☐ Treadmill _____
- ☐ EKG _____
- ☐ PSA, prostate _____

Reason for your visit _____

Family Physician _____

Referring Provider _____

Other Specialists 1) _____2) _____

3) _____4) _____

Olympia Multi-specialty Clinic

Standing Authorization To Verbally Disclose My Health Care Information

Patient name:_____ Date of birth: _____

Patient SSN:_____ Patient OMC Account Number _____

To be filled out by OMC

I. My Authorization

You may verbally disclose the following health care information (check all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating to the following treatment or condition:

_____

☐ Health care information in my medical record for the date(s): _____

You may verbally disclose health care information regarding testing, diagnosis, and treatment for:

☐ HIV (AIDS virus)

☐ Sexually transmitted diseases

☐ Psychiatric disorders/mental health

☐ Drug and/or alcohol use

You may verbally disclose this health care information to:

Name: _____ Relationship: _____

Phone Number: _____

☐ *And no others*

Name: _____ Relationship: _____

Phone Number: _____

☐ *And no others*

Name: _____ Relationship: _____

Phone Number: _____

☐ *And no others*

Reason(s) for this authorization (check all that apply):

☐ at my request

other (specify)_____

This authorization:

☐ ends on (date): _____ OR ☐ 90 days OR ☐ 1year

☐ ends when the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I also understand that this authorization **only** covers verbal disclosures. Washington State law (RCW 70.02) requires that a written authorization be signed for releases of protected health information other than verbal disclosures, and a written authorization of that type is **only** good for 90 days.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Olympia Multi-specialty Clinic based upon this authorization. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from our office. Or
- Write a letter to the Olympia Multi-specialty Clinic.

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

Olympia Multi-specialty Clinic

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 compels us to do so. You may see your record or get more information about it by contacting our Business Office at (360) 704-3450 or 406-A Black Hills Lane SW, Olympia, WA 98502.

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.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

(Notation, if any, by staff)

This form will be retained in your medical record.

THE EPWORTH SLEEPINESS SCALE (ESS)

Patient Name:	Account:	Date:
Patient Age:	Patient Gender:	

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = Would *never* doze

1 = *Slight* chance of dozing

2 = *Moderate* chance of dozing

3 = *High* chance of dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking with someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

When you have completed the questionnaire add together all of the answers to get a score.

- There is a total score range of 0-24
- A total score of less than 10 suggests the person is not suffering from excessive sleepiness.
- A total score of 10 or more suggests further evaluation is needed to determine the cause of excessive sleepiness or determine if underlying sleep disorder may be present.

Olympia Multi-specialty Clinic

Sleep Center
3920 Capital Mall Drive SW Ste 302
Olympia, WA 98502
Phone: 360-236-1451 Fax: 360-236-1450

Date:

Dear Patient,
Per our conversation, I am providing you a list of your appointment dates for your sleep study and follow up appointments.

Sleep Study (Polysomnography) - _____ at _____ AM / PM

Follow up appointment - _____ at _____ AM / PM

Sleep Study (CPAP Titration - _____ at _____ AM / PM

Please complete all the paperwork prior to coming in. If you were given a consent form, please sign and mail it back using the return stamped envelope enclosed. When you present to the office for your appointment our window will be closed, but we will leave a doorbell on the counter for you to ring. You may then have a seat and the sleep technician will call you back when they are ready.
As a courtesy, you will receive a reminder call the day before each appointment. If you are interested in checking your insurance benefits before the study, we will provide the codes so you may contact your insurance company.

Please do not hesitate to call with any questions.
We look forward to serving you

Thank you
OMSC Staff