OLYMPIC
MEDICAL
HEART CENTER
IN AFFILIATION WITH
SWEDISH Heart & Vascular Institute

840 N. 5th Avenue, Suite 2400, Sequim, WA, 98382 ♦ (360) 565-0500 ♦ Fax (360) 582-2841

Cardiology Appointment Reminder

Patient Name: ______________________ Date of Birth: ______________

Appointment Address: **840 N. 5th Avenue, Suite 2400, Sequim**

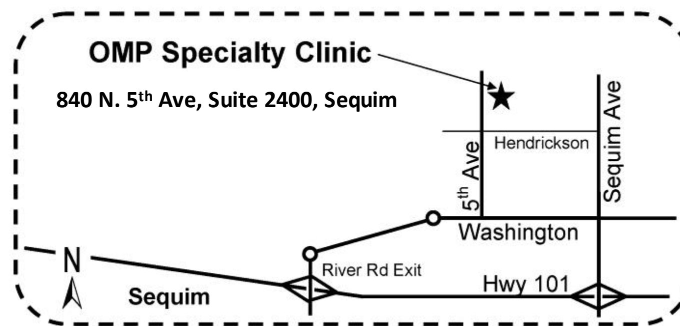
Appointment Date: ______________________ Check In Time: ______________

Provider: ❑ Dr. Henson ❑ Dr. Pan ❑ Dr. Urnes ❑ Tracy Zaher-Lee, ARNP

Please do the following:

- **Fill out all of the enclosed forms.**
- **Bring** the **completed forms** to your appointment**.**
- **Bring** your **insurance cards**, **photo ID** and any **Advanced Healthcare Directive** you may have (IE. POLST form, Durable Power of Attorney for Healthcare, etc) to your appointment.
- **Bring any medications** you are currently taking**.**
- Please contact us at (360) 565-0500 if you need to reschedule or cancel your appointment.

Directions:



If you are coming from Port Angeles:

1. Follow US-101 E
2. Take the River Rd exit
3. Turn LEFT onto River Rd.
4. Turn RIGHT onto Washington St.
5. At the traffic circle, continue STRAIGHT to stay on Washington St
6. At SECOND light turn LEFT onto 5th Ave
7. At light continue STRAIGHT on 5th Ave OMP Medical Services Building will be the on the RIGHT

If you are coming from East of Sequim:

1. Head NORTHWEST on US-101 W
2. Take the Sequim Ave exit
3. Turn RIGHT onto Sequim Ave
4. Turn LEFT onto Washington St.
5. Turn RIGHT onto 5th Ave
6. At light continue STRAIGHT on 5th Ave OMP Medical Services Building will be the on the RIGHT

Thank you for choosing OMP Specialty Clinic!

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

OLYMPIC MEDICAL PHYSICIANS

Patient History

PLEASE PRINT This information becomes part of your confidential medical record

Name:______________________________________ **Date of Birth:**___________________

Primary Care Provider:_______________________________ **Referring Provider:**______________________

Presenting Problem: Please describe the specific problems or questions you would like to have addressed

Medications (include supplements and over the counter drugs)

Name	Dose	Frequency	Purpose

Pharmacy/ Local: Mail Order:

Allergies

Agent	Reaction

Past Surgical History

Type of surgery	Date	Surgeon/City	Reason

Family History

Relationship	Age	Medical Conditions / Cause of death
Mother	❑ deceased	
Father	❑ deceased	
Brother(s) #____	❑ deceased	
Sisters(s) #____	❑ deceased	
Children #____	❑ deceased	

Social History / Habits

❑ Married ❑ Single ❑ Divorced **Children:** ❑ No ❑ Yes if yes: Number of Children:_______

Sexually Active: ❑ Yes ❑ No

Occupation:____

Smoking/Tobacco: ❑ Never ❑ Yes, year started:_____________ ❑ Quit; year quit:______________

cigarettes: ❑ Yes ❑ No pks/day:

cigars: ❑ Yes ❑ No cigars/day:

smokeless: ❑ Yes ❑ No cans/day:

Alcohol: ❑ Yes ❑ No drinks/day:

Marijuana: ❑ Yes ❑ No amt:

Street drugs: ❑ Yes ❑ No type:

Caffeine: ❑ Yes ❑ No type: cups/day:

Exercise: ❑ Yes ❑ No type: amount:

Name:______________________________ Date of Birth:__________________

Medical History (Please mark any conditions you've been diagnosed with in the past)

- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular degeneration
- ❑ Hearing loss
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Angina
- ❑ HIV/AIDS
- ❑ Diverticulitis
- ❑ Hepatitis
- ❑ Reflux / GERD / Ulcers
- ❑ Hiatal hernia
- ❑ Kidney stones
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Stroke
- ❑ Seizure / Epilepsy
- ❑ Anemia
- ❑ Blood clots
- ❑ Arthritis
- ❑ Psoriasis
- ❑ Eczema
- ❑ Depression
- ❑ Fibromyalgia
- ❑ Gout
- ❑ Atrial Fibrillation/Arrhythmia
- ❑ Heart Attack
- ❑ Coronary Artery Disease
- ❑ Congestive heart failure
- ❑ Pacemaker
- ❑ Asthma
- ❑ COPD / Emphysema
- ❑ Tuberculosis
- ❑ Pulmonary embolus

Cancer: Type:______________________________

Other:

For children less than 5 years old: Birth Weight__________ ❑ **Complications** ❑ **Breech**

Review of Systems (Please complete the following by checking Yes or No)

General	YES	NO
Fever		
Chills		
Weight loss		
Malaise/Fatigue		
Sweating		
Weakness		

Skin	YES	NO
Rash		
Itching		

HENT	YES	NO
Headaches		
Hearing loss		
Ringing in ears		
Ear pain		
Ear discharge		
Nosebleeds		
Congestion		
Upper airway wheezing		
Sore throat		

Eyes	YES	NO
Blurred vision		
Double vision		
Light sensitivity		
Eye pain		
Eye discharge		
Eye redness		

Cardiovascular	YES	NO
Chest pain		
Palpitations		
Shortness of breath laying down		
Pain in limbs		
Leg swelling		
Shortness of breath at night		

Respiratory	YES	NO
Cough		
Coughing up blood		
Sputum production		
Shortness of breath		
Wheezing		

Gastrointestinal	YES	NO
Heartburn		
Nausea		
Vomiting		
Abdominal pain		
Diarrhea		
Constipation		
Blood in stool		
Black stools		

Genitourinary	YES	NO
Painful urination		
Urgency		
Frequency		
Blood in urine		
Flank pain		

Musculoskeletal	YES	NO
Muscle pain		
Neck pain		
Back pain		
Joint pain		
Falls		

Endo/Heme/Aller	YES	NO
Easy bruise/bleed		
Environmental allergies		
Excessive thirst		

Neurological	YES	NO
Dizziness		
Tingling		
Tremor		
Loss of feeling		
Speech change		
Focal weakness		
Seizures		
Loss of consciousness		

Psychiatric	YES	NO
Depression		
Suicidal ideas		
Substance abuse		
Hallucinations		
Nervous/Anxious		
Insomnia		
Memory loss		

Other:

Contraception: ❑ Yes ❑ No Type:____________ Vaginal Deliveries: #____________ C-Section: #____________

Last Menstrual Period: ____________________ Miscarriages / Abortions #____________

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:________________________

OLYMPIC MEDICAL CENTER

Financial Assistance Plain Language Summary

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.

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.

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