Lower Elwha Health Clinic

Welcome to our Clinic…

What services do we offer?

- Acupuncture
- Primary Care
- Dental
- Nutrition/ Diabetes Education
- Mental Health
- Benefits Coordination
- Paratransit Transportation

And what does it take to become a patient?

- New patient packet filled out
- Previous Medical records and any medical history
- Tribal ID/ Certificate of Indian Blood (CIB)
- Photo ID (Parents for child patient)
- Insurance Card(s)
- Social Security Card
- Children need a birth certificate or placement document

To sign up for Health Insurance: (Benefits Coordination)

- Washington Health Plan Finder application filled out
- Current 30 days of income
- Need to know your tax filing status and add any dependents on your application.

LOWER ELWHA HEALTH CLINIC
PATIENT MEDICAL HISTORY

Please complete this form so that we can better provide care for your health needs.

Patient Name:_____ Date of Birth ____-____-____

Last Name First Name MI Month Day Year

What is the purpose of your visit to our office today? _____

Do you have pain now? ☐ Yes ☐ No If yes, for how long?_____Where?_____

On a scale of 0-10, 10 being the most painful, what is your pain level today? _____Pharmacy_____

How confident are you filling out medical forms by yourself? (Check one)

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Extremely

If you are unsure of how to answer any of the questions, please ask a staff member for help.

Please respond by circling the number that mostly closely answers	**Not At All**	**Several Days**	**Over Half the Days**	**Nearly Every Day**
Over the past 2 weeks, have you had little interest or pleasure in doing things?	0	1	2	3
Over the past 2 weeks, have you felt down, depressed, or hopeless?	0	1	2	3

Personal Safety

Do you feel safe at home? ☐ Yes ☐ No Would you like to discuss your safety with a provider? ☐ Yes ☐ No

Have you ever had any of the following conditions?	**Yes**	**No**	**Dates if known and short description**
Circulatory System			
Congenital heart disease, defect, palpitations, or heart murmur?			
Heart disease or congestive heart failure? Edema?			
Heart attack?			
High blood pressure (hypertension)?			
Bacterial endocarditis?			
Chest pain or angina?			
Anemia or abnormal bruising or bleeding?			
Do you have a pacemaker, defibrillator, or other artificial heart device?			
Do you take blood thinners (e.g. Plavix, baby aspirin, Coumadin, warfarin)?			
Immune System			
Organ transplant or on organ transplant list?			
Spleen removed?			
Addison's or Cushing's disease, chronic steroid use (e.g. prednisone, etc.)			
HIV or AIDS, or do you believe you have been exposed?			
Lupus, rheumatoid arthritis, or any autoimmune condition?			
Irritable bowel syndrome, Crohn's disease, stomach ulcers, or gastric bypass?			
Cancer, tumors, chemotherapy, or radiation?			
Do you take medications that suppress your immune system (e.g. Remicade)?			
Excretory System			
Kidney problems, including dialysis?			
Hepatitis? If so, what type and is it currently active?			
Do you have any type of liver condition?			
Endocrine System			
Diabetes? If yes, what type?			
Thyroid problems of any kind? If yes, was it high or low thyroid?			
Do you take a thyroid medication (e.g. Synthroid, levothyroxine)?			
Nervous System			
Stroke? Residual effects?			
Epilepsy, seizures, multiple sclerosis or a nervous system disorder?			
Hearing: Implants? Hearing Aids?			
Musculoskeletal System			
Osteoporosis or taken medicine for osteoporosis? Please list.			
Joint replacement (hip, knee, ankle, shoulder)?			
Osteoarthritis (i.e. degenerative arthritis)?			

→ *Continued on next page*

LOWER ELWHA HEALTH CLINIC
PATIENT MEDICAL HISTORY

	Yes	No	Dates if known and short description
Respiratory System			
Asthma or chronic lung disease (e.g. emphysema, COPD, chronic bronchitis)?			
Tuberculosis, histoplasmosis, cystic fibrosis, blastomycosis?			
Sleep Apnea? Obstructive or Central?			
Reproductive System			
Sexually transmitted disease (STD)?			
WOMEN ONLY – Are you currently:			
Pregnant or potentially pregnant? ☐ Yes ☐ No If yes, how many weeks?			
Breastfeeding? ☐ Yes ☐ No Using birth control (other than physical barrier devices)? ☐ Yes ☐ No			
Substance Use			
Substance abuse (alcohol, drugs, illicit prescription drugs, huffing)?			
Been on Pain Agreement, methadone, or Suboxone?			
Treatment for Substance Use Disorder or in recovery?			
(check all that apply) Do you: ☐ smoke ☐ chew tobacco ☐ vape ☐ use e-cigarettes ☐ use marijuana			
Would you like help quitting? ☐ Yes ☐ No			
General Questions			
Do you have any physical or mental disability requiring special consideration?			
Experienced vertigo, dizziness, or fainting?			
Have you ever had any type of operation or surgery? If yes, please list.			
Have you ever been hospitalized? If yes, describe when and why.			
Any disease or condition not listed? If yes, please list.			
Allergies			
Do you have **allergies or reactions** to any of the following:			
☐ chlorhexidine ☐ iodine ☐ lactose ☐ latex ☐ local anesthetics metal ☐ red dye ☐ sulfa ☐ sulfites ☐ tree sap			
☐ Other (foods, medications, etc.):			

Please list **all medications** you currently take (include over-the-counter drugs and herbal supplements, use separate sheet if needed):

Medication Name	What is it for?	How often do you take it?	What dosage (mg, etc.)?

Date of last medical appointment? ____ - ____ - ____ Purpose of that appointment? _____
Month Day Year

Who is your primary care physician/provider? _____.

Please carefully read and sign the statement below.

The answers I have given above are true to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures by signing below on behalf of myself or the above named minor in my guardianship.

Patient Signature: _____ Date/Time: _____

Provider Signature: _____ Date/Time: _____

**********PROVIDER NOTES**********

Provider Name: _____ Patient Medical Record Number: _____

Notes:

_____

MRN:

Lower Elwha Health Department

243511 Highway 101 West,
Port Angeles,WA 98363
Phone: *360.452.6252* ***Fax:*** *360.452.6274*

PAO 21 Form

Today's Date:	Who is your PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital Status:		
Preferred name:			Pronoun:		
Is this your legal name? [ ] yes [ ] no	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
Mailing Address: City:		State:		Zip:	
Physical Address: [ ] (Check box if same as above) City:		State:		Zip:	
Social Security no.:	Primary phone no.:		Secondary phone no.:		
Occupation:	Employer:		Employer phone no:		
Do you have internet access? [ ] yes [ ] no	Email address:		Preferred method of communication? [ ]PHONE [ ]MAIL [ ]DO NOT CONTACT		

AMERICAN INDIAN / ALASKA NATIVE INFORMATION

Religious Preference:	Tribe of Membership:	Tribal Enrollment Number:
Tribal Blood Quantum:	Other Tribe and Blood Quantum:	Which parent is descendancy through: [ ] Mother [ ] Father

IN CASE OF EMERGENCY

Emergency contact:	DOB:
Relationship to patient:	Home phone no:
Name of relative (Next of Kin):	
Relationship to patient:	Home Phone no:

BILLING INFORMATION

(Please give insurance card to the receptionist)				
Check here if person responsible for bill is patient [ ] **Please proceed to INSURANCE INFORMATION on page 2**				
Person responsible for bill (if different from patient):				
Birth date:	Address:		Home phone:	
Is this person a patient here: [ ] yes [ ] no		Is this patient covered by insurance: [ ] yes [ ] no		
Occupation:	Employer:	Employer address:	Employer phone no.:	

INSURANCE INFORMATION

Please indicate primary insurance:		
Subscriber's name:	Subscriber's S.S. no.:	Birth date:
Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:		
Name of secondary insurance (if applicable):		
Subscriber's name: [ ] same as above	Subscriber's S.S. no.: [ ] same as above	Birth date: [ ] same as above
Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:		

OTHER PATIENT DATA

Ethnicity: [ ] Decline to specify [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Other [ ] Unknown	Race:	Primary language:	Other language spoken:
Are you a migrant worker? [ ] yes [ ] no		Are you currently homeless? [ ] yes [ ] no	
Are you a Veteran? [ ] yes [ ] no		Mother's maiden name:	

OPTIONAL HOUSEHOLD INFORMATION FOR INSURANCE ELIGIBILITY PURPOSES

How many people are in your household?	What's your household income?

HIPPA AND ASSIGNMENT OF BENEFITS

I acknowledge I received the IHS notice of Privacy Practices

Signature: _____ Date: _____

I hereby give the Lower Elwha Health Department permission to leave messages for me regarding lab results, appointments, or procedures. I also acknowledge that it is my responsibility to provide a current phone number. You may contact me by:

[ ] Voicemail/ Answering Machine

[ ] Spouse/significant other or family member who is to have access to my health information

_____(name/phone number)

[ ] Leaving messages with the individuals named below:

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the Lower Elwha Health Department or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

FOR OFFICE USE ONLY

[ ] Ineligible [ ]Direct Care Only [ ] CHS/PRC Eligible

Patient Label Here

DOS: _____

Lower Elwha Health Services
Health Clinic, 243511 HWY 101 West, Port Angeles, WA 98363
Dental Clinic, 243511 HWY 101 West, Port Angeles, WA 98363
Behavior Health, 243511 HWY 101 West, Port Angeles, WA 98363
Klallam Counseling Services, 243613 HWY 101 WEST, Port Angeles, WA 98363

ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I hereby authorize direct payment of medical benefit to the provider of services at the Lower Elwha Health Clinic. If I do NOT qualify for Indian Health Services benefits, I understand that I am financially responsible for any balance not covered.

I certify that even if I am eligible for Indian Health benefits that I have disclosed any and all other insurance eligibility in this application. I also certify that all information provided is accurate according to my knowledge at this time.

I hereby authorize the provider to release all information necessary to secure payment of insurance.

I understand that this release will be valid for one year from date signed or unless there is a change in Insurance coverage when I have to sign and date a new AOB/ROI.

CONSENT TO TREAT

I have voluntarily presented myself at the Lower Elwha Health Department. Unless I specifically indicate otherwise, I give consent to evaluate, examination, testing and treatment recommended by the Health Care Professionals and other appropriately authorized professional staff members under the Lower Elwha Health Department.

I understand that in order to provide appropriate care, my provider will share copies of my pertinent records with consulting provider who I am referred to.

I have read and understand the Lower Elwha Health Department Patient Rights and Responsibilities. I will honor these responsibilities and require that I be granted these rights by the staff of the Lower Elwha Health Department.

This consent for medical care shall hold valid for all future visits unless I specifically discuss otherwise with my Provider at the time of a treatment is proposed or prescribed.

Patient Signature: _____ **Date:** _____

Printed Name: _____

Entered By: _____ Date: _____

Instructions for Completing this Form
Lower Elwha Health Department Authorization for use or Disclosure of Protected Health Information

1) Print legibly in all fields using dark permanent ink.
2) Section I, print your name or the person whose information is to be released.
3) Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4) Section III, select the box next to the reason why the information is needed, e.g., disability claim, transfer of care, legal, research, etc.
5) Section IV, check the appropriate box as applicable.
   a) **Only information related to -** specify diagnosis, injury, operations, special therapies, etc.
   b) **Only the period of events from** – specify date range, e.g., Jan1, 2002 to Feb. 1, 2002.
   c) **Other (specify) -** e.g., CHS, Billing, Employee Health.
   d) **Entire Record-** complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/ referral, sexually transmitted diseases, HIV/AIDS- related treatment, and mental health other than psychotherapy notes.) ***Usually the past 2 years from date of request is prepared per release unless otherwise specified.***
   e) **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/ REFERRAL, HIV-AIDS RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT.**
   f) **PSYCHOTHERAPY NOTES ONLY- IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH THE AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate to the medical record and are used by the mental health or psychotherapy provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

6) **Section V, if different expiration date is desired, specify new date.**
7) **Section V, Please sign (or mark) and date**
8) **A copy of the completed Authorization of Disclosure will be given to you.**

PLEASE ALLOW MEDICAL RECORDS STAFF 15 BUSINESS DAYS (MONDAY-FRIDAY, NOT INCLUDING WEEKENDS) TO SEND DISCLOSED RECORDS TO YOUR INDICATED FACILITY. IF YOU WANT TO RELEASE RECORDS TO YOURSELF THERE WILL BE A CHARGE FOR THE FIRST 30 PAGES WILL BE $1.17 PER PAGE. ADDITIONAL PAGES ARE $0.83 PER PAGE WITH A CLERICAL FEE OF UP TO $26.00 FOR RESEARCHING, HANDLING AND COPYING OF THE RECORDS.

UP TO 10 PAGES OF YOUR RECORD CAN BE COPIED FOR YOU AT NO COST IF YOU INTEND TO PERSONALLY TAKE THEM TO ANOTHER PROVIDER ONE TIME. OTHERISE A WELLNESS HANDOUT AS A SUMMARY OF YOUR CARE MAY BE REQUESTED AS YOU LEAVE THE CLINIC.

LOWER ELWHA HEALTH CLINIC, 243 511 WEST HWY 101, PORT ANGELES, WA 98363
PH: (360)452-6252, MEDICAL RECORDS EXT 7614 FAX: (360)452-6274
NOTE: All sections must be completed in full to be accepted

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. **(Name of Patient)**

II. **The information is to be disclosed by:** **and is to be provided to:**

Name of facility:	Name of Facility/ Organization/ Person: **Lower Elwha Health Clinic**
Address:	Address: **243511 HWY 101 W**
City/State/Zip:	City/State/Zip: **Port Angeles, WA, 98363**
Phone: Fax:	Phone: **360.452.6252** Fax: **360.452.6274**

III. **The purpose or need for this disclosure is:**

☐ **Further medical care** ☐ **Attorney** ☐ **School** ☐ **Transfer of care** ☐ **Research**
☐ **Personal use** ☐ **Insurance** ☐ **Disability** ☐ **Other**

IV. **The information to be disclosed from my health record: (check appropriate box or boxes below)**

☐ **Only information related to** _____
☐ **Only the period of events from** _____ **to** _____
☐ **Other (specify) Contract Health, Billing, etc.** _____
☐ **Entire Record (usually 2 years of records)** _____

If you would like any of the following sensitive information disclosed, INITIAL each box you would like disclosed.

☐ **Alcohol/ Drug Abuse Treatment**
☐ **Mental Health (other than Psychotherapy notes)**
☐ **HIV/AIDS Treatment**
☐ **Psychotherapy Notes ONLY**
☐ **Sexually Transmitted Diseases (by checking this box I am waiving any psychotherapist-patient privilege)**

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance of this authorization. If this authorization was obtained as a condition of obtaining medical insurance coverage or a policy of insurance, other lay may provide the insurer with the right to consent a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration event is stated. (Specify new date of expiration):_____

_____

I understand that the Lower Elwha Health Clinic will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) for the sole purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Drug/Alcohol Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 [5 USC 552a].

Signature of Patient or Personal Representative (state relationship to patient)	**Date**
Signature of Witness (if signature of patient is a thumbprint or mark)	**Date**

Name:	**DoB:**
Address:	
City/State/Zip	**Chart Number:**

SEE OTHER SIDE OF FORM FOR COPYING, HANDLING CHARGES AND TIME TO COMPLETE REQUEST

PATIENT MEDICAL NO SHOWRULES

Every day we get many calls for appointments; from both established and new patient. Most of the time, our appointments spaces are already full. Each day, about 1/3 of the patients who have appointment do not keep them or do not call to cancel their appointments. These appointments could be used for other patients. **If you are a new patient, you should plan to be here 20mins before your appointment;** this provides adequate time to complete paperwork necessary for updating your medical record. **If you are an established patient, plan to be here 15mins** before your appointment time so that you record can be updated.

We must cut down on the number of patients who do not keep their appointments so there will be appointments available to treat others who need to be seen. The following ruled will apply:

1. You will be a **NO SHOW if You:**
   - **didn't show up at all.**
   - **didn't cancel at least 24 hours before your appointment.**
   - **didn't check-in at the front desk before your appointment time.**
2. **You will be offered care on a work-in basis if:**
   - **You do not keep your first, regular appointment with us.**
   - **You are an established patient who no-showed three times within six months and did not call to cancel.** After your third "no show" visiting you will be notified by letter that you access to medical care will be on a work in basis.
3. **We are not refusing to take care of you.** However, you will be asked to come in at the beginning of the morning or at the beginning of the afternoon. You will not be given a regular appointment. **You can be seen by you provider on a work-in basis** only for a period of 60 days. If your provider is unavailable, you may need to be seen by another provider that day.
4. To make things easier, you can call and **leave a message which will cancel your appointment. The telephone number is (360)452-6252.** The voicemail system will note the date and time of your telephone call.

THESE GUIDELINES ARE MEANT TO HELP SERVE YOU BETTER

☐ **By initialing this box I am stating that I have read and agree to the above text.**

My signature below means I have ready and initialed all of the above sections of this document and that I agree to the terms and conditions outlined above.

SIGNATURE_____

DATE_____

REFERRAL POLICY

BENEFITS OF REFERRALS AND KEEPING APPOINTMENTS WITH SPECIALIST

1. There is a high probability your condition will be treated by the specialist
2. You will receive additional information to improve your health
3. Your primary care provider will receive feedback from the specialist on how to help you with your problem(s).

THE RESULT OF MISSING YOUR SPECIALTY APPIONTMENT

The results of missing your appointment without properly notifying the specialist's office are far-reaching

It causes:

1. Misses opportunity for the specialist to help you and your provider with your medical problem(s).
2. Disruption & inefficiency in the specialist's office because of wasted time, effort, and paperwork involved in preparing for a patient who does not arrive.
3. Loss of revenue for the specialist
4. Disrupted relationship between the specialist and you primary care provider.

PATIENT RESPONSIBILITY FOR REFERRALS

1. It is your responsibility to call the specialist and reschedule as soon as you are aware of any problems that will make you unable to attend your appointment.
2. It is your responsibility to call and reschedule a specialist appointment if you are a NO SHOW for a scheduled appointment
3. It is your responsibility to return calls to the specialist's office when the specialist is trying to call and schedule an appointment.

CONCEQUENCE FOR NON COMPLIANCE OF REFERRALS

For **NO Shows,** failure to cancel and reschedule an appointment if aware you cannot make appointments, your failed response to call from specialist office to make an appointment; there will be **NO** more routine referrals written for you by your provider for **one year.**

If you feel there is a misunderstanding regarding your referral you will need to make an appointment with your provider to appeal the decision of no more referral for one year.

☐ **By initialing this box I am stating that I have read and agree to the above text.**

FINANCIAL WAIVER

I understand that medical services provided by the Lower Elwha Health Clinic are my responsibility for payment. I also understand that if I have insurance coverage, the Lower Elwha Health Clinic will make every effort to bill my insurance based upon the most current information supplied by me. If my insurance is not in effect for any reason, or that services for medical care are denied by my insurance due to pre-existing conditions, non-eligibility or deductible, I understand that I will be billed personally and will make payments arrangements with the **billing department whose phone number is: (360)452- 6252 extension 7643**

*It is also my understanding that diagnostic laboratory and radiology services may be ordered as part of my medical care and that these services are not a part of the billing from the Lower Elwha Health Clinic. I understand that these outside facilities will be sending their itemized bills from their business addresses.

☐ **By initialing this box I am stating that I have read and agree to the above text.**

Lower Elwha Health Clinic Medication Management Notice

Long term chronic conditions and illnesses may require that you take medications on a continuing basis. The more medications that you take, the more complicated will be your treatment plan. Our general policy is to prescribe enough of your medication(s) to last until your next required appointment.

All prescribed medications are important to your health. Taking them as directed is important. You will need to call and schedule an appointment with your provider if you wish to discuss any of the following:

- You experience side effects that make you stop taking the medication
- You cannot afford your medication(s)
- You have any other concerns about your medication regimen
- You are on your last refill
- You need to make changes to your current medication(s)

Narcotics and Benzodiazepines:

If you are taking any narcotic, benzodiazepine, or any medication listed below, for a chronic pain condition your medical provider ***is not obligated*** to provide prescriptions for these during your fist visit, unless you have prior medical records delivered before your appointment.

NARCOTICS	BENZODIAZEPINES
Oxycodone	Alprazolam = Xanax
Percocet/ Percodan/ Roxicet/ OxyContin	Diazepam = Valium
MS Contin/ Morphine	Lorazepam = Ativan
Dilaudid/ Hydromorphone	Clonazepam = Klonopin
Vicodin/ Hydrocodone/ Norco	
Demerol	
Methadone	
Codeine	
Fentanyl/ Duragesic Patch	
Buprenorphine-naxalone = Suboxone	

In all cases, your new Lower Elwha Health Clinic (LEHC) provider may not agree with the previous provider's chronic pain treatment plan and LEHC may create a treatment plan based on our clinic policies. If you are not prepared to discuss other treatment options and changes to your treatment plan, you may want to reconsider if you will chose Lower Elwha Health Clinic for this service.

I have read and understood the above notice:

_____ _____

Printed Name of Patient or Responsible party | Signature of patient/ Responsible Party

_____ _____

Date of Birth of Patient | Date signed