Lower Elwha Health Clinic

Welcome to our Clinic...

What services do we offer?

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

What does it take to become a patient?

- Fill out a new patient packet
- Previous medical records and medical history
- Tribal ID/ Certificate of Indian Blood (if applicable)
- Photo ID (Parents ID for children)
- Insurance Card(s)
- Social Security Card (if applicable)
- Children need a birth certificate or placement document

We offer assistance in applying for health insurance (Benefits Coordination) you will need to:

- Fill out a Washington Health Plan Finder application
- Bring proof of income (last 30 days)
- Tax filing status and any dependents listed on your application.
- You may also apply for the Sliding Fee Discount Program if qualified

Lower Elwha Health Department
243511 HIGHWAY 101 WEST,
PORT ANGELES, WA 98363
PHONE: 360.452.6252 FAX: 360.452.6274

PATIENT REGISTRATION FORM

Today's Date:	HRN:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

AMERICAN INDIAN / ALASKA NATIVE INFORMATION

Religious Preference:	Tribe of Membership:	Tribal Enrollment Number:
Tribal Blood Quantum:	Other Tribe and Blood Quantum:	Are you a Veteran? ◯ Yes ◯ No
Fathers Name:	Birthplace:	Tribe of Membership:
Mothers Maiden Name:	Birthplace:	Tribe of Membership:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
Name of relative (Next of Kin):	Relationship to patient:	Home phone no.:	Work phone no.:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Name of primary insurance:			Subscriber's name:		
Relationship to subscriber:	Subscriber's S.S. no.:	Birth date:	Policy number:	Group number:	Co-payment: $
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber:					

OTHER PATIENT DATA

Ethnicity:	Race:	Primary Language:	Other Language Spoken:
Are you a migrant worker?	◯ Yes ◯ No	Are you currently homeless?	◯ Yes ◯ No
Do you have internet access?	◯ Yes ◯ No	What is your email address?	What is your preferred method of communication? [ ] PHONE [ ] MAIL [ ] DO NOT CONTACT

HOUSEHOLD INFORMATION FOR INSURANCE ELIGIBILITY PURPOSES **OPTIONAL

How many people are in your household?	What is your total household income?

HIPAA AND PATIENT RIGHTS

I acknowledge I received the IHS notice of Privacy Practices and LEHD Patient Rights and Responsibilities

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.

Patient/Guardian signature Date

FOR OFFICE USE ONLY

Ineligible	Direct Care Only	CHS Eligible

DOS: _______________

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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.

FINANCIAL WAIVER

I, ______________________________________ understand that payment for medical services provided by the Lower Elwha Health Clinic are my responsibility. 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 provided by me. If my insurance is not in effect for any reason, or services for medical care are denied by my insurance due to pre-existing conditions, ineligibility, or deductible, I understand that I will be billed and will be required to pay for services out of pocket. If needed, I will make payment arrangements with the Billing Department at: (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 billed from the Lower Elwha Health Clinic. I understand that these outside facilities will bill me separately for services provided in their office.

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.

I understand 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 /Guardian Signature Date:

____

Printed Name:

Entered By: _______________________________ Date: _______________

Instructions for Completing this Form

Note: All sections must be completed in full to be accepted

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) THE APPROPRIATE BOX OR BOXES MUST BE CHECKED BY THE PATIENT. **In order to release sensitive information regarding alcohol/drug abuse treatment/ referral, HIV-aids related treatment, STD testing and treatment, mental health (other than psychotherapy notes),**
   f) **ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM in order to authorize the use or disclosure of psychotherapy notes. 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, AN ADDITIONAL 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. Otherwise, a wellness handout as a summary of your care may be requested as you leave the clinic.

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 Department
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** ☐ **HIV/AIDS Treatment** ☐ **Sexually Transmitted Diseases**
☐ **Mental Health (other than Psychotherapy notes)** ☐ **Psychotherapy Notes ONLY** (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:

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Medical No Show Rules and Referral Policy

If you are a **new patient,** you should plan to be here **20 minutes** 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 **15 minutes** before your appointment time so that your record can be updated.

We must cut down on the number of patients who routinely do not keep their appointments. Be mindful there are other patients waiting to be seen. The following rules will apply:

NO SHOW RULES

You will be a NO SHOW if:

- You **didn't' show up at all**
- You **didn't cancel at least 24 hours before your appointment**
- You **did not 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 6 months and did not call to cancel.** After your third "no show" visit you will be notified by letter that your access to medical care will be on a work in basis.

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 your 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.

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

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 Specialist Appointment

The result of missing your appointment without properly notifying the specialist's office are far-reaching. It causes:

1. Missed opportunity for the specialty to help you and your provider with you 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 your primary care provider.

CONTINUED ON REVERSE

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Medical No Show Rules and Referral Policy

PATIENT RESPONISBILITY FOR REERRALS

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.

CONSEQUENCES FOR NON COMPLIANCE OF REFERRALS

For NO SHOWS and Failure to cancel and reschedule an appointment if you know you cannot make the appointment

1.Your failed response to call the specialists office and notify of cancellation or to reschedule will result in NO routine referrals written for you by your LEHD provider for one year from date of last referral.

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 a one year wait.

I understand and agree to the rules listed above

____________________________________ ________________

Parent or Guardian Signature Date

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, with 10 being the most painful, what is your pain level today? ______

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.

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)?			
Respiratory System			
Asthma or chronic lung disease (e.g. emphysema, COPD, chronic bronchitis)?			
Tuberculosis, histoplasmosis, cystic fibrosis, blastomycosis?			
Sleep Apnea? Obstructive or Central?			

→ *Continued on next page*

LOWER ELWHA HEALTH CLINIC
PATIENT MEDICAL HISTORY

	Yes	No	Dates if known and short description
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

	Yes	No	Dates if known and short description
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

	Yes	No	Dates if known and short description
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.			
History of HPV or HPV vaccine? If yes, please specify.			
Any disease or condition not listed? If yes, please list.			

Personal Safety

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

Allergies ☐ I do not have any 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 ☐ penicillin

☐ other (foods, medications, etc.):

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

☐ I do not take any medications or supplements

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:

____

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, and may determine these medications are not in the best interest of your overall care. Prior medical records will need to be delivered before your appointment for review before any narcotics or benzodiazepines are prescribed.

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