# 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:** _____ **Birthdate:** _____
Last First MI

☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Separated ☐ Other_____

**Address**_____
Street City State Zip

***Email Address**_____ **(Required under new healthcare laws)**

**Mailing Address**_____
Street City State Zip

**Telephone**_____**Social Security #**____-_____-_____
Home Work Cell

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

**Spouse's Name**_____**Social Security #**_____-_____-_____

**Spouse's Employer**_____ **Telephone**_____

## IF PATIENT IS A MINOR (Under 18 Years)

**Responsible Party**_____**Relationship**_____

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

**Address**_____
Street City State Zip

**Employer's Name & Address**_____

**Telephone**_____ _____
Home Work

## REFERENCE:

**Name of a relative or friend living at another address:**

**Name:**_____**Relationship:**_____

**Address:**_____**Telephone**_____
Home Work

_____

**Whom may we thank for referring you?** _____

*PLEASE COMPLETE REVERSE SIDE*

## INSURANCE INFORMATION:

**Primary Insurance:**_____ **Group#**_____

**Subscriber Name**_____ **Subscriber ID # or SS #**_____-____-_____

**Effective Date:**_____ **Date of Birth**_____ **Relationship:** _____

**Secondary Insurance:**_____ **Group#**_____

**Subscriber Name**_____ **Subscriber ID # or SS #**_____-____-_____

**Effective Date:**_____ **Date of Birth**_____ **Relationship:** _____

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**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:**_____

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**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:**_____

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**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:**_____

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**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:**_____

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**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:**_____

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**ELECTRONIC MEDICATION HISTORY - AUTHORIZATION**

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

**Signature:**_____**Date:**_____

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**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
☐Incontinence

**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

**Sleep disorder**
☐Sleep apnea
☐Sleeplessness
☐Snoring

**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 _____
- ☐ Pneumonia Vaccine _____
- ☐ DXA (for osteoporosis)_____
- ☐ Flu Shot _____

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:**

☐ is Indefinite ☐ ends on (date): _____

☐ 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

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

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