PATIENT INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Race	Religion	E-mail Address
Daytime Phone	Marital Status	DOB	Social Security #	Gender
Mother's Name (If patient is a minor)	Father's Name (If patient is a minor)

GUARANTOR	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone	Relationship to Patient	DOB	Social Security #	Gender
Employer
Employer's Address	City	State	Zip
Employer's Telephone Ext.	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown

PATIENT EMPLOYMENT	Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Self ☐ None ☐ Unknown
Occupation	Employer
Address	City	State	Zip
Employer's Telephone Ext.	Employer's Telephone Ext.

PRIMARY INSURANCE	Primary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer

SECONDARY INSURANCE	Secondary Insurance Company
Relationship to Subscriber	Policy Effective Date
Insured Name	Subscriber ID or Medicare No.
Group No.	Plan No.
Subscriber's Employer

NEXT OF KIN INFORMATION	Last Name	First Name	Middle Initial
Permanent Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

PERSON TO NOTIFY	Last Name	First Name	Middle Initial
Address	City	State	Zip
Home Telephone:	Daytime Telephone:	Relationship:	

MEDICAL CONSENT

I consent to all medical and surgical treatment, laboratory, diagnostic imaging and other medical procedures performed or prescribed by the health care provider during clinic visits.

_____ _____

Signature *Date/Time*

FINANCIAL RESPONSIBILITY, RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for any unpaid balance. I hereby authorize my insurance benefits to be paid directly to my provider. I authorize my provider or insurance company to release information required for processing my claims.

_____ _____

Signature *Date/Time*

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize treatment of the above patient who is a minor and hereby state that I am the natural parent or legal guardian having custody of the named minor.

_____ _____

Signature *Date/Time*

MEDICARE PATIENTS:
STATEMENT TO PERMIT PAYMENT OF MEDICARE TO PROVIDER & PATIENTS

Name of beneficiary_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished to me at Island Hospital Family Care Clinics. I authorize any holder of medical or other information about me to release to the health care financing administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature *Date/Time*

ANACORTES FAMILY MEDICINE/THE WALK-IN CLINIC AT ISLAND HOSPITAL
NEW PATIENT PEDIATRIC MEDICAL HISTORY QUESTIONNAIRE

Name:	Birthdate:	Today's Date:

PARENTS - PLEASE HELP US BY ANSWERING THE FOLLOWING QUESTIONS ABOUT YOUR CHILD'S HISTORY

	YES	NO	COMMENTS
Problems during pregnancy?			
Child born at full term?			If late or early - how many weeks?
Normal, vaginal delivery?			
Problems after delivery?			His/her birth weight:
Any smokers in the house?			
Has your child:			Breast fed?
Been Hospitalized? (please descibe)			
Had any major injury/illness? (please describe)			Does either parent smoke?
Taken long-term medications? (please describe)			
Had any allergic reactions? (please describe)			To what?
Is he/she up to date with immunizations?			
His/her last complete check-up date:			Previous primary physician:
Concerns about his/her development:			
Medications:			

FAMILY HISTORY:	LIVING		DECEASED	
	Age	Health (Good Fair Poor)	Age at Death	Major Illnesses
Father				
His Father				
His Mother				
Mother				
Her Mother				
Her Father				
Brother(s)				
Sister(s)				

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ONE OR MORE OF THE FOLLOWING?	YES	NO	Specify who
Alcoholism			
Allergies			
Arthritis			
Asthma			
Bleeding disorders			
Cancer			
Diabetes			
Heart attacks			
Heart disease			
High blood pressure			
Kidney problems			
Mental illness			
Seizures			
Strokes			
Thyroid problems			

Please list things you would like to discuss with your child's provider today and any information you feel is important

PLEASE SIGN:

_____ Date: _____

Parent and/or guardian

AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____ Medical Record #: _____

Former Name or Alias (if any): _____ Social Security #: _____

Daytime Telephone: _____ Birth Date: _____/_____/_____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I hereby authorize _____

_____

and/or Dr.(s) _____ to discuss my medical information with the following individuals:

Name:	**Relationship to Me:**	**Phone#:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Expiration date of authorization or event:

_____

SIGNATURE OF PATIENT AUTHORIZING DISCUSSION OF HIS/HER PERSONAL HEALTH CARE INFORMATION WITH THE ABOVE NAMED INDIVIDUALS:

_____	_____	_____
Date/Time	Signature of Patient or Legally Responsible Party	Relationship to Patient

Patient ID Sticker

ISLAND HOSPITAL

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Island Hospital respects your privacy. It is required to maintain the privacy of your health information and to provide you with a notice ("Notice") of its legal duties and privacy practices. We understand that your personal health information is very sensitive. Island Hospital will not use or disclose your health information except as described in this Notice. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. This Notice applies to all of the medical records generated by Island Hospital and its personnel, volunteers, students and trainees. This Notice also applies to other health care providers that come to Island Hospital to care for patients, such as physicians, physician assistants, therapists, and other health care providers who are not employed by Island Hospital, such as ambulance services and emergency medical technicians who may have brought you to the Hospital, unless those other providers give you their own Notice that describes how they will protect your medical information. The Hospital and these other health care providers work together to provide you with care and they will share your health information with each other as necessary to care for you, to obtain payment for that care, or for health care operations purposes, such as quality assessment and utilization review.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. Island Hospital is required to follow the privacy practices that are described in this Notice (which may be amended from time to time).

Permissible Uses and Disclosures Without Your Written Authorization

We may use and disclose your protected health information without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are legally permissible.

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan with your consent. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management and insurance services;
  - audit functions, including fraud and abuse detection and compliance programs.

Required or Permitted by Law:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
  - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public
  - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury or disability
    - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Work Related Circumstances under the following conditions:**
  - the employer must have requested the health care service that was provided to the patient.
  - the healthcare service provided must relate to the medical surveillance of the workplace or be an evaluation to determine whether the individual has a work-related illness or injury.
  - the employer must have a duty under the Occupational Safety and Health Administration (OSHA), or requirements of a similar State law, to keep records on or act on such information.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request or in accordance with state and federal law.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

For fundraising:

- We may use your protected health information to contact you in an effort to raise money for our operations. We may also disclose your health information to a foundation that is related to us so that the foundation may contact you in an effort to raise money for our benefit. Any fundraising communications with you will include a description of how you may opt out of receiving any further fundraising communications.

Permissible Uses and Disclosures that may be made without your authorization, but for which you have an opportunity to object:

You have the right to object to our use or disclosure of your protected health information for the following purposes. If you object, we will not use or disclose it for the purpose(s) you specify.

- **Notification of Family and Others.** We may release health information about you to a family member, other relative, close personal friend, or any other person you identify to us who is involved in your medical care, which is directly relevant to such person's involvement with your health care. We may also give information to someone who helps pay for your care. We may tell your family or friends your general condition and that you are in a hospital.

- **Disaster Relief Efforts.** We may disclose health information about you to assist in disaster relief efforts.

- **Directory.** Information may be provided to people who ask for you by name. We may use and disclose the following information in a hospital directory:
  - your name,
  - location,
  - general condition, and
  - religion (only to clergy).

Uses and Disclosures requiring your written authorization:

We may use and disclose your protected health information for the following purposes only after we obtain your written authorization for such uses:

- **Psychotherapy Notes**. We must obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes, (2) for our own training programs in which mental health students, trainees or practitioners learn under supervision to practice or improve their counseling skills, (3) to defend ourselves in a legal proceeding initiated by you, (4) required by law, (5) to a health oversight agency with respect to the oversight of the originator of the psychotherapy notes, (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

- **Marketing Communications; Sale of PHI.** We must obtain your written authorization prior to using or disclosing PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

Other Uses and Disclosures of Protected Health Information

Uses and disclosures not described in this Notice will be made with your written authorization. You may revoke any such authorization at any time by providing us with written notification of such revocation.

Your Health Information Rights

The health and billing records we create and store are the property of Island Hospital. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to agree to any restriction you may request, except if your request is to restrict disclosing protected health information to a health plan for the purpose of carrying out payment or health care operation, the disclosure is not otherwise required by law, and the health information pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You must make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to amend your health information. You must give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures made for purposes of treatment, payment or health care operations, disclosures you authorized,

disclosures to you, incidental disclosures, disclosures to family or other persons involved in your care, disclosures to correctional institutions, and law enforcement in some circumstances, disclosures of limited data set information or disclosures for national security. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.

- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.
- Receive a notification if we discover a breach of your protected health information, according to requirements under federal law.

For help with these rights during normal business hours, please contact:

Privacy Officer
Island Hospital
1211 24th Street
Anacortes, WA 98221
(360) 299-1300

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice and place the updated Notice on our website and post it in appropriate locations. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our Admitting or Medical Records departments to pick one up.

To Ask for Help or Report a Concern

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Privacy Officer
Island Hospital
1211 24th Street
Anacortes, WA 98221
(360) 299-1300

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Privacy Officer at Island Hospital. You may also file a complaint with the U.S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Web Site

- We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at this address: www.islandhospital.org.

Effective Date: 8.1.2013

ISLAND HOSPITAL

Name _____

BD / MR# _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge that I received a copy of the Notice of Privacy Practices for Island Hospital.

_____ _____

Signature of patient (or personal representative) Date

_____ _____

Printed Name Relationship to patient

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ¤ Individual refused to sign
- ¤ Communication barriers prohibited obtaining the acknowledgement
- ¤ An emergency situation prevented us from obtaining acknowledgement
- ¤ Other (Please Specify)

_____

_____

_____

This form will be retained in your medical record.