PROVIDENCE
Medical Group
West Olympia Family Medicine

Providence West Olympia Family Medicine New Patient Information & Clinic Policies

WELCOME TO YOUR MEDICAL HOME: Thank you for choosing Providence West Olympia Family Medicine as your medical home. We appreciate the opportunity to provide you with exceptional team-based care. Our medical home team consists of Family Physicians, Sports Medicine, Physical Therapy, Behavioral Health, a Pharmacist, and a Dietitian. Our team looks forward to our involvement in your healthcare and in keeping you well.

MYCHART HEALTH RECORD IS OUR PRIMARY MODE OF COMMUNICATION: MyChart gives you online access to your health record. Whether you are at work, on the road, or at home, you may view test results, messages from your provider and team, access your medical record, and make and cancel your own appointments. Ask how to sign up today!

EXPERIENCE THE MEDICAL HOME DIFFERENCE: We view you as a key partner in your care. One of the advantages of a medical home is that you will have the opportunity to establish a continuous relationship with your personal care team, led by your primary care provider. We will coordinate your care so that you see the appropriate team member for your visit or specific needs.

TELL US HOW WE ARE DOING: We strive to provide the highest level of service. To help ensure you receive the best care possible, we encourage you to participate in decisions regarding your care and treatment plans. We periodically will send surveys following your appointment and rely on your responses to help us know where we are succeeding and where we have opportunities for improvement. We always welcome your feedback and if you have any questions, concerns, or comments, please let us know during your visit or give us a call at (360) 486-6710.

PROVIDENCE WEST OLYMPIA FAMILY MEDICINE CLINIC HOURS: Monday through Friday, 7:00am-6:00pm

LAB HOURS: Monday through Friday 8:00am-5:00pm. Closed for lunch 12:30pm-1:30pm
DIAGNOSTIC IMAGING: Monday through Friday 8:00am-8:00pm, Saturday-Sunday 9:00am-5:00pm
ULTRASOUND: Monday through Friday 8:00am-7:30pm, Saturday-Sunday 9:00am-4:30pm

SAME DAY APPOINTMENT REQUESTS: Our providers have appointment times reserved for same-day visit requests and we do our best to accommodate these requests. If your primary physician is not available, you may be offered an appointment with a different physician in our office for evaluation of an acute problem, or for certain conditions, with a registered nurse. Requests for these same day appointments should be made by phone.

MEDICAL QUESTIONS OR CONCERNS: If you need to speak to someone on your care team about a medical concern, please call us at (360) 486-6710, option 1 for Family Medicine then option 3 for our clinical team. If a team member is not immediately available at the time you call, please leave a message and we will return your call as promptly as possible. MyChart is also a valuable resource for you to reach your care team with questions or concerns. We ask that you do not drop-in to the clinic without an appointment as we are not equipped for emergent care.

AFTER HOURS: *If you have a medical emergency, please call 9-1-1.* If you have an urgent medical concern and need to reach the provider on-call after normal clinic hours, please call the clinic and follow the prompts. The on-call physician will call you back to discuss your concerns, and send your primary care physician the documentation of the call. Prescription refills, referral questions, or appointment requests are not considered an urgent medical concern and the provider on-call cannot address or assist with these requests.

IMMEDIATE CARE: In the event that you have an urgent medical concern that needs to be addressed before your primary care team can see you, you have the option of receiving care at our Immediate Care Clinics. This is a walk-in clinic and on busier days, patients may experience extended wait times. The providers at Immediate Care do not provide, refill, or prescribe controlled substance medications.

IMMEDIATE CARE HOURS: Monday through Friday, 8:00am–730pm; Saturday and Sunday, 9:00am–430pm

WEST OLYMPIA IMMEDIATE CARE:	1620 Cooper Point Rd SW, Olympia WA 98502	**Phone: 360-486-6710**
LACEY IMMEDIATE CARE:	4800 College St SE, Lacey WA 98503	**Phone: 360-486-2900**
HAWKS PRAIRIE IMMEDIATE CARE:	2555 Marvin Rd NE, Lacey WA 98516	**Phone: 360-493-4450**

FEES: Your co-payment is due at the time of service. There are a few exceptions, such as preventative exams, nurse visits, and injections. If you have no insurance coverage, payment is due at the time of service. We accept cash, check, money order, and most major credit cards. Providence does offer options for payment plans or financial assistance; please contact the business office at 866-747-2455 for more information or to make arrangements.

ANNUAL PHYSICALS AND WELLNESS EXAMS: Please check with your insurance company prior to the visit to see if this is a covered benefit. If you have a specific problem to be addressed the same day as your preventative exam, the physician may reschedule the treatment of that specific problem for another day.

MEDICATIONS: The medications prescribed for you are those that your primary care provider feels would most benefit your specific condition. If you need a prescription refill, please call your pharmacy and ask them to fax us a refill request. You may also request a refill through MyChart. Please allow at least 72 business hours to process refills. Many insurance companies place certain limitations or requirements on medication coverage and while we strive to work within these parameters, it is important for you to know your insurance company may not cover all medications prescribed.

> **CONTROLLED SUBSTANCE PRESCRIPTIONS:** Available for pickup Monday-Friday 7:00am-4:00pm (excluding holidays). These can only be picked up by the patient to whom they are prescribed. Must have photo ID for pick-up.

REFERRALS: Many insurance companies require referrals for you to see specialists, have certain tests, or receive other forms of treatment. It is important that authorizations be in place prior to receiving the appropriate care. Most referrals take at least 72 business hours to process, but there are occasions where it can take longer. When we submit a referral, it does not always mean approval will be granted. Due to insurance coverage, we suggest you check directly with your insurance company so you understand your benefits. If you self-refer outside of Providence Health System, please inform us so we can obtain the records from your visit.

YOUR MEDICAL RECORDS/FEES: Your right to privacy is very important, and your medical record is confidential. In order for us to release your medical records, you must sign a records release form, which are available at our office or on our website.

MISSED APPOINTMENTS/CANCELLATIONS: Because your health is important to us, we want to see you in a timely manner. Arriving on time for your scheduled appointment is greatly appreciated, but we understand that unanticipated circumstances can arise. We allow a 10 minute window for patients to arrive. If you are more than 10 minutes late to your appointment, you risk the appointment being rescheduled. If you need to cancel or reschedule your appointment, we kindly request that you give us 24 hours' notice. Patients who miss multiple appointments without advanced notice may be asked to leave the practice.

TRANSFER OF CARE/RE-ESTABLISH CARE: If for any reason you transfer your care to a provider outside of Providence Medical Group, please notify us so we can update your medical records. If for any reason you are not seen in our clinic for 3 years, you will need to re-establish care as a new patient.

My signature acknowledges that I have read and understand the policies of my provider's office as stated above.

_____ _____

Patient Name, *please print* Date of birth

_____ _____

Patient Signature

REGISTRATION FORM

PROVIDENCE Medical Group
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PATIENT INFORMATION				
LAST NAME:	FIRST NAME:	MIDDLE NAME:	MARITAL STATUS: (Circle one) Single / Married / Divorced / Widowed/ Other	
MAIDEN NAME:	ALIASES:	DATE OF BIRTH:	SEX: ☐ M or ☐ F	Social Security Number:
STREET ADDRESS (MAILING ADDRESS):				
CITY:	STATE:	ZIP CODE:		
HOME PHONE:	CELL PHONE:	WORK PHONE:		
EMAIL:	ETHNICITY:	RACE:		
INTEPRETER NEEDED? ☐ YES ☐ NO	PREFERRED LANGUAGE:	DEAF OR HARD OF HEARING? ☐ YES ☐ NO	BLIND OR LOW VISION? ☐ YES ☐ NO	
PRIMARY CARE PROVIDER YOU ARE SCHEDULED TO SEE:	PREVIOUS PRIMARY CARE PROVIDER:			

EMPLOYMENT/OCCUPATION		
EMPLOYMENT STATUS: ☐ Full-time ☐ Part-time ☐ Retired ☐ Student ☐ Other _____		RETIREMENT DATE (IF APPLICABLE):
EMPLOYER:	OCCUPATION:	EMPLOYER PHONE NUMBER:
EMPLOYER ADDRESS:		

INSURANCE AND BILLING INFORMATION			
Guarantor (Person Responsible for Bill) ☐ ***Self***			
LAST NAME:	FIRST NAME:	MIDDLE NAME:	RELATIONSHIP TO PATIENT
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	HOME PHONE:	
STREET ADDRESS (IF DIFFERENT):			
EMPLOYEMENT STATUS:	OCCUPATION:	EMPLOYER:	
EMPLOYER ADDRESS:	EMPLOYER PHONE NUMBER:		

Insurance Information

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company		
Subscriber Name and Date of Birth ☐ Same as Patient ☐ Same as Guarantor		
Subscriber's Employer ☐ Same as Patient ☐ Same as Guarantor		
Subscriber's Social Security Number ☐ Same as Patient ☐ Same as Guarantor		
Relationship to Patient		
Subscriber ID #		
Subscriber Group #		

EMERGENCEY CONTACTS		
PRIMARY CONTACT:		RELATIONSHIP TO PATIENT:
HOME PHONE:	CELL PHONE:	
SECONDARY CONTACT:		RELATIONSHIP TO PATIENT:
HOME PHONE:	CELL PHONE:	

Pediatric Medical History

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Today's Date: _____/_____/_____

Dear Parent:
Please fill out this questionnaire to give us a more complete record for your child. Skip any questions you can't answer or that don't apply.
Thank you.

Patient Name:_____ **Age:** _____ **Birthdate:**_____/_____/_____

Preferred Name & Pronoun (if different):_____

Sex: ☐ Male ☐ Female

Pregnancy and Birth

Birth weight _____ lbs. _____oz. ☐ Born at term OR ☐ Born premature (<37 weeks) at _____weeks

Was the delivery ☐ Vaginal OR ☐ C-Section If C-Section, explain: _____

_____

Any problems with the pregnancy, labor or delivery? ☐ Yes ☐ No If yes, explain_____

_____

Was the baby breech at any point during the third trimester or at birth? ☐ Yes ☐ No

Was a NICU stay required? ☐ Yes ☐ No If yes, explain _____

_____

During pregnancy, did the mother: ☐ Use tobacco ☐ Use drugs or medications
☐ Drink Alcohol ☐ Take prenatal vitamins

Did your baby go home with mother from the hospital? ☐ Yes ☐ No If No, please explain _____

_____

Was initial feeding: ☐ Formula ☐ Breast Milk How long breastfed? _____

Prior Medical Care

Please list any other providers who are currently involved in your care

_____

Who was your previous primary care provider? _____

Past Medical History and Review of Systems

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No If yes, explain_____

_____

Has your child ever been hospitalized overnight? ☐ Yes ☐ No If yes, explain _____

_____

Has your child had any surgery? ☐ Yes ☐ No If yes, explain _____

_____

Does your child have any allergies to medications or foods? ☐ Yes ☐ No If yes, explain _____

_____

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Does your child have, or has your child ever had any of the following: *(please circle)*

Asthma
Allergic rhinitis/nasal allergies
ADHD
Autoimmune or other immune problems
Arthritis/Rheumatologic disorder
Anxiety
Anemia or other blood problems
Bed-wetting (after 5 years old)
Cancer/chemotherapy
Chronic or recurrent skin problems (eg. acne, eczema)
Constipation requiring doctor visits
Developmental delays
Depression/Mood Problems
Diabetes
Eye conditions/corrective lenses
Fractures
Frequent ear infections
Frequent sinusitis
Genetic/Metabolic disorder
Heart problems/murmurs
Frequent Headaches
Problems with ears or hearing
Other respiratory/lung problems
Recurrent urinary tract infections
Seizures, convulsions, or other neurological problems
Use of alcohol, tobacco, drugs
Obesity
Thyroid problems
Delayed or missing immunizations
(For Girls) Problems with periods
Has had first period at _____ age

Any other significant problems
_____
_____

Immunizations:

Immunization history – If you have your child's immunization records, please give to the nurse or receptionist.

Is your child behind on his/her immunizations? ☐ Yes ☐ No

If yes, please explain_____

Any reactions to immunizations? ☐ Yes ☐ No

If yes, please explain_____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medication and type of reaction)

Name of Medication, X-Ray Dyes, etc	Reaction

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Please bring ALL medications with you to your first appointment. If additional room is needed, please list on a separate page.

Medication Name	How Much? (Dose)	How Often? (Frequency)

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Social History

Is your child in daycare? ☐ No ☐ Yes

If No, who cares for your child during the day?_____

Does anyone in your home smoke? ☐ No ☐ Yes

Does your family have pets? ☐ No ☐ Yes If Yes, specify type:_____

What is the child's living situation if NOT with both biological parents?

☐ Joint custody ☐ Single Custody ☐ Lives with adoptive parents ☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Who lives at home with your child?_____

_____

School Progress, if applicable:

Academic: _____

Social: _____

Athletic: _____

Any recent significant changes in your child's home, school, or social situation? ☐ No ☐ Yes

_____

_____

Patient Health Questionnaire (PHQ-2)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	○ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	○ 0	○ 1	○ 2	○ 3

Family History

If unknown or adopted ☐

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Relationship	Name	Alive	No known problems	Arthritis	Asthma	Autism	Birth defects	Cancer	COPD	Depression	Diabetes	Early Death	Hearing Loss	Heart Disease	Premature CHD	High blood pressure	High cholesterol	Kidney disease	Learning disability	Mental illness	Developmental delay	Miscarriages/Stillbirth	Stroke	Substance Abuse	Vision Loss	Other
Mother		Y N																								
Father		Y N																								
Sister		Y N																								
Brother		Y N																								
Daughter		Y N																								
Son		Y N																								
Maternal Aunt		Y N																								
Maternal Uncle		Y N																								
Paternal Aunt		Y N																								
Paternal Uncle		Y N																								
Maternal Grandmother		Y N																								
Maternal Grandfather		Y N																								
Paternal Grandmother		Y N																								
Paternal Grandfather		Y N																								

FAMILY HISTORY: Please check the box of any medical condition that one of your relatives has been affected by. If you have anything to add please feel free to comment below or on a separate piece of paper.

We appreciate you taking the time to fill out our forms.

10/2019

West Olympia Family Medicine Authorization to Release Protected Health Information

Patient Name: _____ **Date of Birth**: ____/____/____

Mailing Address: _____

Phone: _____ **Previous Name** (If Applicable): _____

I hereby request and authorize the following release of information:

Information to be released **BY**: **Provider:** _____

Phone: _____ **Organization**: _____

Fax: _____ **Address**: _____

Information to be released **TO**:

Phone: **(360) 486-6710_** Organization: **PROVIDENCE Medical Group – West Olympia Family Medicine_**

Fax: **(360) 412-2253_** Address: **1620 Cooper Point Road SW, Olympia, WA 98502_____**

INFORMATION TO BE RELEASED: ☐ All ☐ Date(s) or date range_____

☐ My health information relating the following condition or treatment: _____

☐ Billing Information ☐ Other: _____

INCLUDE the following information from my records released (please initial):

I understand that my records may contain information regarding the following sensitive diagnosis or treatment.

If the item is initialed, then I give my specific authorization for these records to be released.

____ Drug/Alcohol abuse diagnosis/treatment ____ Sexually Transmitted Diseases

____ HIV/AIDS testing/diagnosis/treatment ____ Mental Illness/Psychiatric diagnosis/treatment

PURPOSE FOR DISCLOSURE:

☐ Patient's Request ☐ Continuing Care ☐ Legal ☐ Insurance ☐ Transfer of Care

☐ Other (explain): _____

This Release expires on the following date or when the following event occurs:

Date: ____/____/____ OR Event: **90 days after signing**_____

MY RIGHTS

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form in order to take part in a research study OR to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Providence based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the clinic's Medical Records. OR
- Write a letter to the clinic, **Attention: Privacy Officer**

Once Providence discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

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

If signature is of a personal representative of the patient, please complete the following:

Personal representative's name: _____ Relationship to patient:

☐ Parent ☐ Legal Guardian*

☐ Power of Attorney for Healthcare*

☐ Other*: _____

**Attach legal documentation if you are a personal representative other than parent*

For Official Use Only

Release of Information completed by:

Name: _____

Clinic: _____

Date: _____/_____/_____

PROVIDENCE Health & Services

AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION

Patient Identification:

Align Patient ID Here