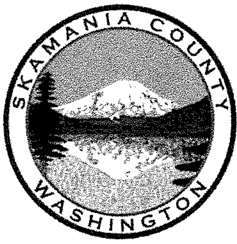


Skamania County Community Health
Annual Client Registration Form
Public Health
710 SW Rock Creek Drive, Stevenson WA 98648
509-427-3850

Patient Information			
Client Name: (Last, First, MI)			
Other names you have been known by:			
Date of Birth: Gender at Birth: M / F	Social Security #		
Mailing Address: (Street, Apartment, City, State, Zip Code)			
Is Mailing Address Confidential? YES / NO	**Would you like confidential services? YES / NO**		
Physical Address:			
Home Phone #	Mobile Phone #		
Is Home # Confidential? YES / NO	Is Cell # Confidential? YES / NO		
Marital Status: ☐ Single/Never Married	☐ Married	☐ Separated/Divorced	☐ Widowed

Emergency Contact Information	
Name:	Relationship to Patient:
Phone:	Other Phone:

Assistance			
Are you visually or hearing impaired?	☐ Visually Impaired	☐ Hearing Impaired	☐ No
Do you need an interpreter?	☐ Yes ☐ No	What is your preferred language?	

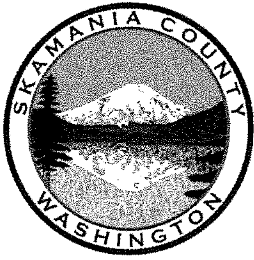
Identity			
What is your current gender identity?	☐ Female ☐ Male ☐ Trans-Female to Male	☐ Trans-Male to Female ☐ Other:	
Do you think of yourself as:	☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual	☐ Something else ☐ Don't know ☐ Other:	
How would you like us to address you?	☐ She/Her/Hers ☐ He/Him/His	☐ They/Them/Theirs ☐ By Name	☐ Don't know ☐ Other:
Ethnic Group (choose one)	☐ Hispanic	☐ Non-Hispanic	☐ Unknown
Race (choose one)	☐ Alaskan Native ☐ Black ☐ Unknown	☐ American Indian ☐ Native Hawaiian	☐ Asian ☐ Pacific Islander ☐ White

Insurance Coverage ****If you are covered under someone other than yourself and are seeking confidential services do not complete****	
Insurance Company:	Subscriber Name:
Group Number:	Policy/Member ID:
Medicaid P1 #	Medicare #

Client Signature: ______________________________ **Date:** ____________

Signature of Interpreter: ______________________________ **Date:** ____________

Revised 6/2019



Skamania County Community Health
Public Health Department

NOTICE OF PRIVACY PRACTICES—ACKNOWLEDGEMENT

I have been given the Notice of Privacy for Skamania County Public Health:

____
Print patient/client name

____ ________________
Signature of patient/client or authorized individual Date

____ ________________
Printed name if signed on behalf of patient/client Relationship

____
Interpreter's Signature

____
Date

SKAMANIA COUNTY COMMUNITY HEALTH REPRODUCTIVE HEALTH ANNUAL INCOME VERIFICATION WORKSHEET

Place patient label here

Client Name:

Date of Birth:

Number of people in the household that are supported by the income listed below →	#________
Please write down any money you **AND** anybody else in your family or household receive.	Amount:
Salaries, wages, tips (include seasonal and part-time): ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually ....→	$________
Public Assistance/Social Security Benefits: ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually ....→	$________
Unemployment Benefits/Sick Pay/Workers Compensation: ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually ....→	$________
Child Support or Alimony: ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually ....→	$________
Contributions from your parents, relatives and/or non-relatives: ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually ....→	$________
Military/Veterans' Benefits: ☐ weekly ☐ bi-weekly ☐ monthly ☐ annually ....→	$________

I have told the truth about **ALL** sources of my family's income to the best of my knowledge and have not given false/withheld information.

Client Signature: ______________________________ Date: ____________

STAFF USE ONLY:

Income verified by: ☐Check stub ☐Letter from employer ☐Verbal ☐Other______________

☐ Weekly Total $____________ Multiply by 4.33 = Monthly Total $____________

☐ Bi-Weekly Total $____________ Multiply by 2.17 = Monthly Total $____________

☐ Monthly Total $____________

☐ Annual Total $____________ Divide by 12 = Monthly Total $____________

Client is at________% pay Final Monthly Total $____________

I have seen this document and witnessed client's signature.

STAFF SIGNATURE & TITLE: ______________________________ DATE: ____________

SKAMANIA COUNTY COMMUNITY HEALTH
Insurance Authorization & Financial Policy

Authorization to Bill Insurance

I hereby authorize my consent for Skamania County Community Health to bill my insurance carrier(s) for any services rendered to myself and/or my dependents.

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, state provided insurance and any other health/medical plan, to issue payment check(s) directly to Skamania County Community Health for services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by my insurance.

Authorization to Release Information

Insurers and managed care companies occasionally review medical charts to ensure compliance with company procedures. I understand that my chart may be selected for such review. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, my insurance carrier or other medical entity.

I further understand that my records may contain information regarding the diagnosis and treatment of HIV(Aids virus), or other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. A copy of this authorization will be kept on file by the organization and may be revoked by myself at any time in writing.

Financial Policy

Skamania County Community Health will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that if I am on a sliding scale or self-pay for services, that I am expected to make payment in full when I am checking in for my appointment.

Signature____Date___________________

Printed Name____

Skamania County Community Health
Consent for Reproductive Health Services

I am voluntarily seeking reproductive health services from Skamania County Public Health.

I understand that these services may include:

- Reproductive health counseling on birth control, getting pregnant, healthy pregnancies, and other subjects as needed;
- Providing a birth control method;
- A provider visit for a prescription and maybe a physical exam;
- Testing and/or treatment for sexually transmitted infections (STIs);
- Testing for cervical cancer, pregnancy and/or other health problems; and
- Referrals to other services, if needed.

I understand that all services will be explained and I can ask questions.

I understand I may be given information about birth control methods. I can ask questions and refuse any birth control method I do not want to use.

I understand that I won't be refused care if I owe money from other visits.

I understand these services do not include 24-hour care, and in case of a medical emergency, I will need to go to an emergency room and pay its costs.

I understand that the services I receive and my medical records are private, except:

- If a judge issues a subpoena for my records. Skamania County Community Health is required by law to give the records to the court.
- If I have reportable disease, Skamania County Community Health will be required to report it to Washington State Public Health.
- If Skamania County Community Health staff learns of physical and/or sexual abuse of a person under 18 years old or a vulnerable adult, they must report it to social services or law enforcement agencies.
- I understand I may choose not to talk about sensitive information, such as the age(s) of sex partner(s), and that I will still get services.

I understand that if I get reproductive health services here, I can still apply for or get services from other programs. If I get care from other programs, I can still get services at Skamania County Community Health.

I, (print my name) ______________________________, have read and understand the above information, and consent to receive reproductive health services from Skamania County Community Health.

____________________	________	____________________
Client Signature	**Date**	**Witness Signature**
____________________	________	
Interpreter Signature	**Date**	

Skamania County Initial Health History Form
Reproductive Health Program

Today's Date:_______

Please ask the front desk staff if you would like help filling out this form.

Name ____ Date of Birth: _____________
First Middle Last

1. Why are you here today?

____

2. Do you take any **medicines**?
☐ Yes (Please list any prescription, over the counter, vitamins, herbs.) ☐ No, I do not take any medicines.

Name of medicine	Strength/Dose	Why do you take this medicine?
Example: Zrytec	*20 mg*	*Allergies*

3. Have you ever had an **allergic reaction (bad reaction) to a medicine or a shot**?
☐ No, I am not allergic to any medicines.
☐ Yes (Please write the name of the medicine and the reaction you had.)
Medicine(s): ______________________ Reaction: ________________________

4. Do you get an **allergic reaction (bad reaction)** from any of the following (check all that apply)?
☐ No - I have no allergies. ☐ Latex (rubber gloves) ☐ Grass or Pollen
☐ Shellfish ☐ Eggs ☐ Other (please describe): ________________________

5. **Family Health History:**

Family Member	Medical Problems
Mother:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other: ________________________
Father:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other: ________________________
Sister(s):	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other: ________________________
Brother(s):	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other: ________________________

6. Your **health history**: Have you ever had any of the following problems? (Check all that apply)

☐ Anemia (low blood iron) ☐ Asthma (wheezing) ☐ Diabetes (sugar)
☐ Heart Trouble ☐ Cancer ☐ Gallbladder Trouble
☐ Tuberculosis (TB) ☐ Liver Trouble ☐ Blood Clot
☐ Pelvic Inflammatory Disease ☐ Hepatitis ☐ Ulcers
☐ Headaches ☐ High Blood Pressure ☐ Lupus
☐ Epilepsy (fits, seizures) ☐ Depression (feeling down or blue) ☐ Blood Clotting Trouble
☐ Anxiety (nerves, panic attacks) ☐ Exposed to Diethylstilbestrol

☐ Problems with Uterus or Testicles

☐ STD, VD (syphilis, gonorrhea, chlamydia, herpes, warts, HIV, hepatitis B)

☐ Other ______________________________

7. Have you ever been a **patient in a hospital** overnight?
   ☐ No, I have never been a patient in a hospital. (If no, go to question #8)
   ☐ Yes (If yes, explain EACH reason and when)

I was in the hospital because	When
Example: Had tonsils removed	*8 years ago*

8. Have you ever had a **blood transfusion** (when you are given extra blood)? ☐ Yes ☐ No
   If yes, when: ______________________________

9. Have you ever had **surgery** (an operation)? ☐ Yes ☐ No
   If yes, when ______________ Why______________________

10. When was your last **Tetanus shot**? Year: ________ ☐ Never ☐ Don't know

11. Have you had **2 Rubella (MMR) shots** in your life? ☐ Yes ☐ No ☐ Don't know

12. Have you had any **HPV vaccines**? ☐ No ☐Yes, 1 of the 3 ☐ Yes, 2 of the 3 ☐ Yes, all 3
    If yes, when did you get the last shot? ______________

13. Have you ever **smoked cigarettes, cigars, used snuff or e-cigarettes, or chewed tobacco**?
    ☐ Yes ☐ No (if no, go to question #14)
    When did you start? ______________________________
    How much per week? ______________________________
    Do you want to quit? ☐Yes ☐ No ☐ Already Quit

14. Have you ever used **marijuana (pot)**?
    ☐ Yes ☐ No (if no, go to question #15)
    How much per week? ______________________________

15. How many standard drinks containing **alcohol** do you have on a typical day?
    ☐ 0/None ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

16. How often do you have six or more **drinks** on one occasion?
    ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

17. Have you ever used any of the following **drugs** (check all that apply):
    ☐ NEVER ☐ Cocaine ☐ Speed/Meth ☐ Heroin ☐ LSD
    ☐ Prescription drugs that do not belong to you ☐ Other: ______________________

18. Have you ever been **tested for HIV**? ☐ Yes ☐ No

19. Do you have **children** now? ☐ Yes ☐ No
    Do you want (more) children? ☐ Yes ☐ No
    How many (more) children do you want and when? ______________________

20. Do you have **sex** with: ☐ Men ☐ Women ☐ Both ☐ Neither

21. How many **sex partners** have you had in the past year? _____ In the past 3 months? _____

22. Have you ever had a **unprotected sex** with someone who (check all that apply):
    ☐ Used IV drugs, ☐ Had other sex partners while still having sex with you
    ☐ Had HIV or an STD ☐ Had men and women sex partners

23. What do you use for **birth control**? ______________________________
What birth control methods have you used before? ______________________________
What problems have you had with these birth control methods? ______________________________
____

24. Do you use **condoms**? ☐ Yes ☐ No ☐ Sometimes

25. **Safe Relationships**:
- Has your current partner ever threatened you or made you feel afraid? ☐ Yes ☐ No
(*Threatened to hurt you or your children if you did or did not do something, controlled who you talked to or where you went, or gone into rages*)
- Has your partner ever hit, choked or physically hurt you? ☐ Yes ☐ No
- Has your partner ever forced you to do something sexually that you did not want to do, or refused your request to use condoms? ☐ Yes ☐ No
- Does your partner support your decision about when or if you want to get pregnant? ☐ Yes ☐ No
- Has your partner ever tampered with your birth control or tried to get you pregnant when you didn't want to be? ☐ Yes ☐ No

26. In the past two weeks, how often have you been bothered by having **little interest or pleasure in doing things**?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Don't know

27. In the past two weeks, how often have you been bothered **by feeling down, depressed, or hopeless?**
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

FOR WOMEN ONLY

28. Have you ever been **pregnant**? (if no, go to question #30) ☐ Yes ☐ No
How many times? ________ How many children have you given birth to? ______
How many miscarriages? _____ How many abortions? ____ Date last pregnancy ended: ______

29. Are you **breastfeeding** now? ☐ Yes ☐ No

30. Do you have a **period** each month? (if no, go to question #31) ☐ Yes ☐ No
When was the first day of your last period? ____________
Do you have cramps with your period? ☐ Yes ☐ No

31. Have you had a **PAP smear**? (if no, go to question #32) ☐ Yes ☐ No
Date of last PAP: ________________
Have you ever had a PAP smear that was not normal? ☐ Yes ☐ No
Have you ever tested positive for HPV? ☐ Yes ☐ No
Have you ever had a colposcopy (looking at your cervix with a microscope)?
☐ Yes, date of last one______________ ☐ No

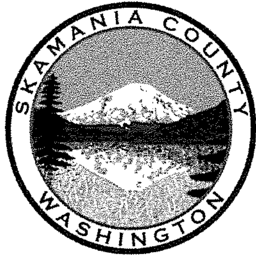
32. Have you had a **mammogram** (breast x-ray)? ☐ Yes, date of last one____________ ☐ No

33. Have you ever been tested **Chlamydia**? ☐ Yes, date of last one______________ ☐ No

Your Signature______________________________ Date:____________________

Staff signature______________________________ Date____________________

Interpreter signature______________________________ Date____________________



Skamania County Community Health
Public Health Department
Notice of Privacy Practices

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

Our Responsibilities:	**You have a right to:**
➢ We are required by law to maintain the privacy and security of your protected health information.	➢ Get a copy of your paper or electronic medical record.
➢ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.	➢ Correct your paper or electronic medical record.
➢ We must follow the duties and privacy practices described in this notice and give you a copy of it.	➢ Request confidential communication. ➢ Ask us to limit the information we share.
➢ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.	➢ Get a list of those with whom we've shared your information. ➢ Get a copy of this privacy notice. ➢ File a complaint if you believe your privacy rights have been violated.

Reference: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/model-notices-privacy-practices/index.html
06/2019