



Skagit Family Health Clinic  
 916 South 3<sup>rd</sup> Street  
 Mt. Vernon, WA 98273-4324  
 Voice: (360) 336-5658  
 Fax: (360) 336-5655  
 www.skagitfamilyhealth.com

**PATIENT MEDICAL HISTORY INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

HEALTH COMPLAINT/REASON FOR TODAY'S VISIT	

MEDICAL HISTORY - List chronic, serious or significant health conditions with date of onset/diagnosis	
Date	Health Condition

SURGICAL HISTORY - List surgeries and dates	
Date	Surgery

MEDICATIONS/SUPPLEMENTS – List current prescription medications, over the counter medications and supplements			
Name	Strength (e.g. 10 mg tablets)	How is it taken (e.g. 10 mg 2x a day)	Daily or as needed

*Please complete other side. Thank you.*

Additional Medical History

<b>ALLERGIES - List all medication allergies and reactions</b>	
Name of Medication	Brief description of your reaction (e.g. rash)

<b>FAMILY MEDICAL HISTORY - List serious health conditions</b>			
Relation	Health Conditions and/or Cause of Death	Age if Living	Age at Death
GRANDPARENTS			
FATHER			
MOTHER			
BROTHERS			
SISTERS			

<b>SOCIAL HISTORY</b>	
Marital Status:	Occupation:
Exercise ( <i>circle</i> ): <i>Active</i> <i>1/wkly</i> <i>1-3/wkly</i> <i>4+/wkly</i> <i>Sedentary</i> <i>Other:</i>	
Alcohol Use ( <i>circle</i> ): <i>Never</i> <i>Currently every day</i> <i>Currently some days</i> <i>Former</i>	
Amount Used:	
Tobacco Use ( <i>circle</i> ): <i>Never</i> <i>Currently every day</i> <i>Currently some days</i> <i>Former</i>	
Amount Used:	Age started:                      Age stopped:
Recreational Drug ( <i>circle, if yes please provide details</i> ):    No    Yes:	

<b>IMMUNIZATIONS HISTORY – List shots, date given and booster number if known (e.g. DTaP 1/2/11, #3)</b>

<b>ADDITIONAL MEDICAL INFORMATION – Please use the space below to list <input type="checkbox"/> any other important information</b>

If you need additional space to complete information use a separate piece of paper, attach to this form and check this box. Thank you.



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**FINANCIAL POLICY**

Thank you for choosing one of the healthcare providers at Skagit Family Health Clinic (SFHC). We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following Financial Policy prior to your visit, and please ask if you have questions.

**CONTRACTED INSURANCE PLANS**

SFHC’s healthcare providers are contracted with most healthcare insurance plans. SFHC will bill them directly, if services at SFHC are not covered by your healthcare insurance, you are responsible for any balance left after payment and/or denial.

**SECONDARY INSURANCE PLANS**

If you have secondary insurance, we will courtesy bill the secondary insurance one time only. It will be your responsibility to pay if the secondary insurance denies payment for any reason. We will not bill secondary insurance if the healthcare provider is not contracted with your primary insurance provider (e.g. Medicare). We do not bill tertiary insurance. **\*Failure to disclose any or all current insurance coverage will result in you being billed for any charges incurred. SFHC will not sort out any coordination of insurance benefits issues.\***

**CO-PAYMENTS AND DEDUCTIONS**

If your policy has an office visit co-payment, you must agree to pay the co-payment at the time of your visit. Failure to do so will result in an additional \$15.00 fee. **Patients are responsible to know the terms of their insurance and whether services are covered.**

**PATIENTS WITHOUT INSURANCE**

We will require a minimum payment of \$50 prior to seeing the provider. The balance is due upon checkout. Just like banks who extend you credit, we require your social security number. If you refuse to provide this form of identification, we will require full payment at the time of service. ***We do offer a discount if full payment is made at the time of service.***

**ALTERNATIVE BENEFITS**

Naturopathy can be considered an alternative therapy that may or may not be covered by your insurance. It is your responsibility to verify before your scheduled appointment that naturopathic doctors are a covered provider type under your specific insurance policy. Even though our providers may be contracted with your insurance, there are provider specialties and services that can be excluded on insurance plans.

**ADDITIONAL CHARGES AND FEES**

For any check that is returned for non-sufficient funds, SFHC will charge an additional \$30.00 to your account and we will not accept your personal checks in the future. You will be asked to remit the amount of the check plus the service charge in cash or with a credit card payment within 10 days. If your account has not cleared by then, we will refer it for collection action.

All monthly statement balances are due within 30 days of the statement date. Any balances over 30 days will be assessed 1% interest per month.

**Patients that “no show” or do not cancel 24 hours prior to their appointment time may be assessed an appointment charge of \$25.** This charge is your responsibility.

When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or the other parent.

**I have read and fully understand SFHC’s Financial Policy. I hereby authorize SFHC to release all information necessary to secure the payment of insurance benefits, and I authorize the use of this signature on all my insurance submissions.**

\_\_\_\_\_  
**Signature of Patient/Guardian**

\_\_\_\_\_  
**Printed Name of Patient**

\_\_\_\_\_  
**Date**



**Demographics**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Preferred Name (if applicable): \_\_\_\_\_ Maiden Name (if applicable): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Preferred Pharmacy (please select one):** \_\_\_\_\_ **City:** \_\_\_\_\_

**Race (check one):** \_\_\_ White \_\_\_ American Indian/Alaska Native \_\_\_ Asian  
\_\_\_ Black/African American \_\_\_ Nat Hawaiian/Pacific Is \_\_\_ Other \_\_\_ Declined

**Ethnicity (check one):** \_\_\_ Hispanic/Latino \_\_\_ Not Hispanic or Latino \_\_\_ Declined

Primary Language (check): \_\_\_ English \_\_\_ Other: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Driver's License State/No: \_\_\_\_\_ Religion: \_\_\_\_\_

*Mother's Name (minors only):* \_\_\_\_\_ *DOB:* \_\_\_\_\_

*Father's Name (minors only):* \_\_\_\_\_ *DOB:* \_\_\_\_\_

*Child lives with:*  both parents  mother  father  other \_\_\_\_\_

*Who will be the guarantor for this account?* \_\_\_\_\_ *Date of Birth:* \_\_\_\_\_

*Address (if different from patient)* \_\_\_\_\_ *Phone:* \_\_\_\_\_

Mailing Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email (required for patient portal): \_\_\_\_\_

Preferred Communications: \_\_\_ Cell phone \_\_\_ Home phone \_\_\_ Work phone \_\_\_ Mail \_\_\_ Email \_\_\_  
\_\_\_ Text

**See Other Side**



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Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Contact's Phone #:** \_\_\_\_\_

**Relation to patient:** \_\_\_\_\_

Primary care provider (PCP)? Dr. \_\_\_\_\_ Phone #: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_

ID Number: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ **If policy holder is the same, check here:**

Policy holder's DOB: \_\_\_\_\_ Policy holder's SSN: \_\_\_\_\_

Relationship to policy holder:  spouse  child  other \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_

ID Number: \_\_\_\_\_ Group/Policy Number: \_\_\_\_\_

Name of policy holder: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship to policy holder:  spouse  child  other \_\_\_\_\_

**See Other Side**



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**Contact & Privacy at Skagit Family Health Clinic**

Patient name: \_\_\_\_\_

**Contact me**

Home Phone: \_\_\_\_\_  
Ok to leave detailed message:  Yes  No

Cell Phone: \_\_\_\_\_  
Ok to leave detailed message:  Yes  No

Work Phone: \_\_\_\_\_  
Ok to leave detailed message:  Yes  No

Email Address: \_\_\_\_\_  
Ok to leave detailed message:  Yes  No

**Sharing** SFHC can share my health info with (i.e. family members):

- Name: \_\_\_\_\_ Relation: \_\_\_\_\_
- Name: \_\_\_\_\_ Relation: \_\_\_\_\_
- Name: \_\_\_\_\_ Relation: \_\_\_\_\_
- Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**\*\*\*This form is not a consent to release records to other provider offices\*\*\***

**Time Limits** share records from:

- Anytime (past/now/future)
- Dates from \_\_\_\_\_ to \_\_\_\_\_

**For How Long**

- Indefinite
- This date/event: \_\_\_\_\_

**Topic Limits** share records:

- General records & include
  - Mental Health
  - Communicable diseases including HIV/AIDs
  - Alcohol/Drug abuse treatment

**Canceling**

I can cancel this permission, in writing, at any time. But I can't retroactively cancel permission.

**After Sharing**

SFHC protects privacy. But SFHC can't control how my designees share information after SFHC has shared it.

**Patient/Guardian's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_