



Columbia Family Clinic

1012 S 3rd St Dayton, WA 99328 • (509) 382-3200

Waitsburg Clinic

235 Main St Waitsburg, WA 99361 • (509) 337-6311

PEDIATRIC

Thank you for contacting the Columbia Family and Waitsburg Clinic regarding your healthcare. To better serve you and allow more time during your visit, these forms need to be filled out **before** scheduling your appointment.

Please also bring the following with you to your appointment:

- Photo ID
- Insurance Card and/or Medicare/Medicaid Card
- List of current medication and/or bring medications with you
- Co-payment

Your medical information is strictly confidential.

We look forward to working with you to meet your health goals.

Sincerely,
Columbia Family and Waitsburg Clinics

Columbia Family and Waitsburg Clinic

Patient Information

Legal Name: _____
First Name Middle Name Last Name

Nickname: _____ (if applicable) Senior ☐ Junior ☐

Date of Birth: _____ Social Security No: _____

Birth Gender: Male ☐ Female ☐ Gender Preference: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____ OR (same as above) ☐

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ Home ☐ Cell ☐

Secondary Phone: (_____) _____ Home ☐ Cell ☐

Primary E-mail: _____

Employer / Occupation: _____ Self-Employed ☐ Retired ☐

Work Phone: (_____) _____ (if applicable)

Emergency Contact

Primary:

Name: _____ Relationship: _____

Contact Phone: (_____) _____ Home ☐ Cell ☐ Work ☐

Secondary:

Name: _____ Relationship: _____

Contact Phone: (_____) _____ Home ☐ Cell ☐ Work ☐

Insurance Information

Primary Insurance: _____

Policy or ID #: (include prefix) _____ Group #: _____

Subscriber's Name: (if not patient) _____

Subscriber's DOB: _____ Relationship to Patient: _____

Secondary Insurance: _____

Policy or ID #: (include prefix) _____ Group #: _____

Subscriber's Name: (if not patient) _____

Subscriber's DOB: _____ Relationship to Patient: _____



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Columbia County Health System is allowed to give verbal/written medical information or updates about your condition to your Power of Attorney or Healthcare/Legal Representatives as listed in your medical records.

If you wish others, such as relatives or friends, **WHO ASK** about your condition, the right to be verbally informed about your condition when they inquire, please list the names of these individuals on the lines below.

I _____ as a patient of CCHS or Legal Representative of the patient, authorize the release of verbal and written medical information regarding treatment, care and updates on patient's condition to the following individuals. **** Please include parents/guardians in the list below. ****

Parent: _____ Relationship: _____

Parent: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ **Date:** _____

This form should be updated annually or upon the request of the patient. This form is to be scanned in to the patient's medical record. All verbal discussions must be documented in the patient's medical record.



Financial Responsibility Agreement

Thank you for choosing Columbia County Health System (Dayton General Hospital, Columbia Family Clinic, Waitsburg Clinic, College Place Health Clinic) for your healthcare needs. We are committed to providing quality care and services to all our patients. **Please thoroughly read and initial the statements** below to acknowledge that you understand this Financial Responsibility Agreement. This agreement is valid for **one year** from the date of responsible party's signature.

_____	I will provide CCHS with current and accurate health insurance information. I understand that providing a copy of my insurance card does not guarantee coverage.
Initial	
_____	I understand that I am responsible for services not covered by insurance and for amounts applied to my deductible, coinsurance, or copay. If I am uninsured or choose not to bill my insurance, I understand that I am financially responsible for all services rendered.
Initial	
_____	I understand that balances are due and payable within 30 days from my first billing statement. I understand that if I am having difficulty with paying my bill, would like to set up payment arrangements, or would like to apply for financial assistance, that I need to contact the Billing Office at 509-382-2531 during normal business hours Monday through Friday between 8 a.m. and 4:30 p.m.
Initial	
_____	I understand that a \$25.00 charge will be added to my account for any check returned by my bank for any reason. This will be in addition to charges made by my bank, if any.
Initial	

Patient or Parent/Guardian Signature

Date

Patient or Parent/Guardian Printed Name

Relationship to Patient

Patient Health Questionnaire

All information is strictly confidential and used only to improve your health care.

Name: _____ **Date of Birth:** _____

Current Medications – Include Over-the-Counter, vitamins and supplements.

Medication Name	Dosage	Instructions

Allergies/sensitivities to medications, foods, insect stings, etc: Include reaction

Family Medical History: Check all that apply and please put who in your family

☐	Asthma	☐	High Blood Pressure
☐	Alcohol/Drug Abuse	☐	Mental Health
☐	Arthritis	☐	Obesity/Weight
☐	Cancer	☐	Stroke
☐	Diabetes	☐	Seizures
☐	Genetic Disorder	☐	Thyroid
☐	Heart Disease		

Past Medical History: Check all that apply

☐	Asthma	☐	Crohn's Disease	☐	Kidney Disease	☐	Heart Valve Disease
☐	A Fib	☐	Depression	☐	Neurological Disorder	☐	UTI
☐	Anemia	☐	Diabetes 1	☐	Osteoarthritis	☐	Abnormal Pap
☐	Anxiety	☐	Diabetes 2	☐	Osteoporosis	☐	Breast Disease
☐	Autoimmune Disorder	☐	Diverticulosis	☐	PVD	☐	Breast Cancer
☐	Blood Transfusions	☐	DVT	☐	Peptic Ulcer Disease	☐	Cervical Cancer
☐	Brain Tumor	☐	GI Bleed	☐	Rheumatoid Arthritis	☐	Diabetes - Gestational
☐	Cerebrovascular Disease	☐	GERD	☐	Seizure Disorder	☐	RH Sensitized
☐	Cirrhosis	☐	Hyperlipidemia	☐	Thyroid Disorder	☐	Total Hysterectomy
☐	CVA/Stroke	☐	Hypertension	☐	Tuberculosis	☐	Total Hysterectomy w/ BSO
☐	COPD	☐	Hypothyroidism	☐	Kidney Stones		
☐	Colon Cancer	☐	Hyperthyroidism	☐	Liver Disease		
☐	Coronary Artery Disease	☐	Hepatitis	☐	MI		

Past Surgical History: Please provide date.

Personal HabitsSeat Belt Use? **Yes** ____ **No** ____**Current Health Concern:**

Additional History: Anything else you think is important

APPOINTMENT SCHEDULING AND NO SHOW POLICY

We will try our best to schedule your appointment at the most convenient time possible. We are open weekdays beginning at 8 am, except Wednesdays when the clinic opens at 9 am, and every 2nd and 4th Saturday from 10 to 2.

When you are unable to keep a scheduled appointment, please call our office prior to your appointment so we may care for someone else during that time. Cancellations must be received 24 hours in advance.

If less than a 24 hour cancellation notice is given this will be documented as a “No Show” appointment; frequent late notice and/or “No Show” appointments (3 or more in one year) can result in dismissal from the practice. Please be courteous to others who are waiting for appointments.

AFTER HOURS MEDICAL CARE

If you are needing to speak with a nurse or physician after hours, please call the office and you will be routed to the after-hours answering service. This service is available outside of our normal hours of operation, holidays, and office closings. The answering service is responsible for paging the physician or provider on call if needed. Please be aware that prescription refills or new prescriptions **are not** completed after hours.

PRESCRIPTION REFILLS

Please allow 48-72 clinic hours for prescription refills. Please make sure you monitor your medications and ask for refills in a timely manner.

I have read the above policies of Columbia Family Clinic

Name: _____ Date: _____



Columbia
County
HEALTH SYSTEM

1012 S 3rd Street, Dayton, WA 99328

Dayton General
Hospital
P: 509-382-3205

Columbia Family Clinic
P: 509-382-3200
F: 509-382-2748

Waitsburg Clinic
P: 509-382-3200
F: 509-337-6011

College Place Clinic
P: 509-382-8349
F: 509-593-4342

Rivers Walk Assisted
Living Facility
P: 509-382-4911
F: 509-593-4911

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ MR#: _____
Address: _____ Telephone#: _____
Previous Name(s): _____ Birth Date: _____
Date Requested By: _____ Upcoming Appointment: ☐ Yes ☐ No

Hereby Authorize:

(Individual/Agency)

(Address)

(City, State, Zip Code)

To Provide Medical Information to:

(Individual/Facility)

(Address)

(City, State, Zip Code)

Permission to fax and/or send electronically ☐ No ☐ Yes - Email and/or Fax#: _____

Dates of Treatment: _____

Data Requested: _____

☐ Physician Notes

☐ History & Physical

☐ All Health Care Records

☐ Operative Reports

☐ X-Rays

☐ Films

☐ Lab/Pathology Report

☐ EKG ☐ Reports

☐ Other: _____

For the purpose of: _____

To be valid, this authorization must be dated within 90 days of the request for information. This authorization may be revoked in writing at any time, provided that the information has not been released. To view the process for revoking this authorization please read the Privacy Notice to our patients. Once Columbia County Health System discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws. The patient understands that they do not have to sign this authorization to receive health care benefits.

Patient Signature

Date/time

Parent/ Legal Guardian or Authorized representative*

Witnessed by

By checking and signing below, I specifically authorize the release of the following confidential information.

☐ HIV test, Test Results, and Related Information

☐ Sexually Transmitted Diseases

☐ Drug/Alcohol Diagnosis, Treatment or Referral Information

☐ Psychiatric Disorders/Mental Health

Patient Signature

Date/Time

Parent/Legal Guardian or Authorized Representative* Date/Time

Please provide documentation to prove authority to sign on behalf of the patient

