Basic Information

Full Name _____
First Middle Last Suffix

Sex ○ Male ○ Female ○ Unknown

Date of Birth ____/____/____

Primary Phone ○ Home ○ Mobile ○ Work

Phone Number _____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ Zip _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License # _____

Demographics

Sexual Orientation _____

Gender Identity _____

Hispanic or Latino? ○ Yes ○ No ○ Decline to Specify

Ethnicity _____

Race _____

Language _____

Emergency Contact

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ○ Home ○ Mobile ○ Work

Phone Number _____

Email _____

Address Line 1 _____

Address Line 2 _____

City _____

State _____ Zip _____

Financial Information

Responsible Party

Who will be financially responsible for you? ○ Myself ○ Someone else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name _____
First Middle Last

Primary Phone ○ Home ○ Mobile ○ Work Phone Number _____

Method of Payment

What will be your method of payment? ○ Insurance ○ Self-Pay

If you chose "Insurance", please fill out the following:

PRIMARY INSURANCE POLICY

Insurance Company _____ Policy Number _____

Insurance Plan _____ Insurance Phone Number _____

Group Number _____

Insurance Company Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ○ Male ○ Female ○ Unknown Date of Birth ___/___/___

Policy ID Number _____ Social Security Number _____

Policy Holder Address _____ Address Line 2 _____

City _____ State _____ Zip _____

If you are unable to provide your insurance information, please provide a reason before continuing.

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ Policy Number _____

Insurance Plan _____ Insurance Phone Number _____

Group Number _____

Insurance Company Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Relationship to Secondary Policy Holder _____

If you are not the secondary policy holder, please fill out the following:

Full Name _____
First Middle Last

Sex ○ Male ○ Female ○ Unknown Date of Birth ___ / ___ / ___

Insurance ID Number _____ Social Security Number _____

Policy Holder Address _____ Address Line 2 _____

City _____ State _____ Zip _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name Pharmacy Address

How did you hear about us? _____

Medical History Form

Patient Name:_____ Date:_____

Patient DOB:_____

Medications/Vitamins/Supplements:

Medication Name	Dose	Frequency	How long have you been taking this medication?

Name of Pharmacy:_____

Allergies: (please list all allergies)

Allergy	Severity

Medical History: (Please mark all that apply)

Condition		Condition	
Diabetes		High Blood Pressure	
Asthma		Heart Attack	
Kidney Disease		Hepatitis	
Thyroid Disease		Stroke	
Depression		Emphysema	
Seizures		Tuberculosis	
Coronary Artery Disease		Congestive Heart Failure	
Arrythmia		Sexually transmitted disease	
Eye Problems		Cancer	
Other:_____			

Surgical History:

Date Performed	Surgical Procedure

Please list any other medical conditions or hospital stays not listed above:

_____

_____

_____

_____

Date of last Medical physical: _____

Date of last Lab Work:_____ Lab used:_____

Specialty Providers:

Provider	Specialty (*Cardiology*)

Family History:

	Mother	Father	Sister	Brother	Grandfather (moms side)	Grandmother (moms side)	Grandfather (dads side)	Grandmother (dads side)	Child	Aunt/Uncle	Other/Type - Please explain
Cancer											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Mental Illness											
Osteoporosis											
Stroke											
Thyroid Disease											
Other											

Health Habits:

	Quantity (how much/many)	Frequency (how many times a day/week)	Quit
Tobacco			
E-cigarette/vape			
Alcohol			
Drugs			
Other			

Personal History:

Are you currently married or living with a partner? Yes No

Who lives with you at home: _____

Are you employed? Yes No

If yes what type of work do you do? _____

If no is this by choice: _____ Disability _____ Other: _____

Do you exercise more than 2 times per week? Yes No

Do you often feel sad or depressed? Yes No

Do you feel that there is something seriously wrong with your body? Yes No

Are you having money problems which limit your access to food, shelter or medical care: Yes No

In the last year, have there been any major changes in your life such as marriage, divorce, death of a family member or close friend, illness or injury, or change in job situation? Yes No

Do you have some form of church or spiritual support? Yes No

Sexual History:

Are you sexually active: Yes No

Do you feel you are at risk for HIV/AIDS? Yes No

Do you have children? Yes No

How many children do you have? _____

Do you use any form of birth control? Yes No

IF yes which type/brand? _____

Women Only:

Have you ever been pregnant? Yes No

How many times? _____

How many live births? _____

How many miscarriages/terminations? _____

Do you have menstrual periods? Yes No

Date of Last cycle: _____

Are your periods regular? _____

If NO, at what age did they stop? ____

Additional Comments:

_____

_____

_____

_____

_____

_____

Patient Health Questionnaire-2 (PHQ-2)

Patient Name:_____ Date:_____

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
Little interest or pleasure in doing things	0	1	2	3
Felling down, depressed, or hopeless	0	1	2	3
For office coding	*0*	+ _____	+ _____	+ _____
				total score = _____

Cascade Community Healthcare
2428 West Reynolds, Centralia WA 98531
Telephone: Adult and Child/Adolescent Services 360-330-9044
FAX Medical Records 360-736-2106

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client—please complete top half of this form (directions on reverse)

Client: _____ _____
(print full legal name of client) *(print former name/s of client)*

Birth Date: *(MM/DD/YEAR)* _____ Phone Number: _____

I understand that the privacy of my health records is protected as follows:

- My mental health records are protected under the Federal Regulations governing confidentiality of health information, including 42 C.F.R. and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 & 164, and the WA Uniform Health Care Information Act, R.C.W. 70.02.
- Alcohol and/or drug treatment records or related to HIV status are protected under the above listed regulations as well as 42 C.F.R. pt 2.
- My protected health information cannot be disclosed without my written consent unless otherwise provided for by the regulations.

This authorization expires _____
(Specification of date, event, or condition upon with this consent expires *EX: at close of episode of treatment*)

unless revoked sooner by client or their authorized representative. I also understand that I may revoke this consent at any time except to the extent that action has been taken by Cascade in reliance on it.

I authorize CASCADE to exchange the following information, in both written and verbal form unless otherwise specified, with:

Name of Agency or Person: _____ Relationship to client: _____

Address: _____

Telephone: _____ Fax: _____

This section to be completed with the assistance of Cascade staff.

The purpose of this authorized disclosure is for:

Client—Initial line(s) below

_____ Intake Evaluation

_____ Psychiatric Evaluation

_____ Progress Notes

_____ Discharge Summary

_____ Other: _____

_____ Primary Care

_____ Alcohol/Drug Identity, Diagnosis, Prognosis

_____ HIV (AIDS Virus), sexually transmitted disease treatment, prognosis, and/or treatment information

Client Signature *(If signing for client- relationship to client, i.e. parent, legal guardian, etc.)*	Date:

Staff Assisting Client: _____ Date: _____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at § § 2.12 (c)(5) and 2.65.

CASCADE
2428 West Reynolds, Centralia WA 98531
Telephone: Adult and Child/Adolescent
Primary Care Services 360-330-9044 x2144
FAX Primary Care 360-669-0058

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Client—please complete top half of this form
(directions on reverse)

Client: _____ _____
(print full legal name of client) *(print former name/s of client)*

Birth Date: *(MM/DD/YEAR)* _____ **Phone Number:** _____

I understand that the privacy of my health records is protected as follows:

- My mental health records are protected under the Federal Regulations governing confidentiality of health informatio including 42 C.F.R. and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. pts 160 & 164, and tl WA Uniform Health Care Information Act, R.C.W. 70.02.
- Alcohol and/or drug treatment records or related to HIV status are protected under the above listed regulations as w 42 C.F.R. pt 2.
- My protected health information cannot be disclosed without my written consent unless otherwise provided for by th regulations.

ROI Start Date: _____
ROI Expiration Date: _____

unless revoked sooner by client or their authorized representative. I also understand that I may revoke this consent at any tim except to the extent that action has been taken by Cascade in reliance on it.

I authorize **CASCADE** to exchange the following information, in both written and verbal form unless otherwise specified,

Name of Agency or Person: _____ **Relationship to client:** _____

Address: _____

Telephone: _____ **Fax:** _____

This section to be completed with the assistance of Cascade staf

The purpose of this authorized disclosure is for:

Client—initial line(s) below

_____ **Intake Evaluation**

_____ **Psychiatric Evaluation**

_____ **Progress Notes**

_____ **Discharge Summary**

_____ **Other:** _____

_____ **Primary Care**

_____ **Alcohol/Drug Identity, Diagnosis, Prognosis**

_____ **HIV (AIDS Virus), sexually transmitted disease treatment, prognosis, and/or treatment information**

Client Signature *(If signing for client- relationship to client, i.e. parent, legal guardian, etc.)* **Date:**

Staff Assisting Client: _____ **Date:** _____

PROHIBITION ON REDISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information that may concern a client in alcohol/drug treatment, made to you with the consent of such client. It this information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertai or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. federal rules restrict any of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Cascade
Community Healthcare

Cancellation and no-show policy/Cascade Community Health Care Primary Care

Cascade Community Health Care values all our patients and the time it takes for them to be seen in our clinic. Cascade has implemented a no show/stand by policy for those patients that miss 3 or more appointments in a 12-month period.

A no-show consists of either failing to show up for a scheduled appointment or cancelling an appointment with less than 24 hours' notice. If a patient has 3 or more no shows in this timeframe, we place them on a standby status.

Standby status simply means that you cannot schedule an appointment for 6 months. During this time, you are welcome to come into the clinic and wait to see if another patient does not make it to their scheduled appointment. At that time, we would put you into the schedule for the day.

By signing this form, you are acknowledging that you are aware of this policy and what it means to be placed on standby status.

Thank you.

Patient Signature: _____

Date: _____