OLYMPIC MEDICAL PHYSICIANS
Women's Health

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840 N. 5th Avenue, Suite 1500 • Sequim, WA, 98382
Phone: (360) 565-0999 • **Fax:** (360) 452-7303

Welcome to Olympic Medical Physicians Obstetrics! Our experienced group practice includes physicians and certified nurse midwives. We are proud of this collaboration that ensures excellent care based on the unique needs of each pregnant person.

About Certified Nurse Midwives (CNMs)

CNMs are registered nurses who have advanced training in Obstetrics and Women's Health and specialize in supporting low risk pregnancy, labor and birth. Personalized, high-touch care is characteristic of the midwifery model. Should a complication of pregnancy develop, midwives work with our physicians to provide safe and appropriate care.

CNMs deliver in the hospital, prescribe medication and order diagnostic tests. All hospital resources, including labor epidurals, are available to CNM patients.

About OMP Physicians

OMP physicians are board-certified, providing obstetrics and gynecology as well as surgical care. Our physicians manage low risk and complicated pregnancies. They have specialty training in the management of high-risk obstetrics and obstetrical surgery, including C-sections.

Preparation for your first visit

Your first visit may be an ultrasound with one of our midwives to confirm dating of your pregnancy and check that everything is progressing as it should. Please be aware that this ultrasound is done vaginally.

Please prepare for your first visit by doing the following:

1. Complete and **bring the enclosed registration paperwork to your appointment**. Please do not mail or email these forms.
2. Bring a copy of your photo ID and current insurance card(s).
3. Bring all medications you are taking in their original bottles, *including* herbs and supplements.
4. Arrive to your appointment 15 minutes early and be prepared to leave a urine specimen.
5. Do not bring children to this first visit. Siblings, family and friends are welcome to attend all other appointments at your discretion and per OMC's visitor policy.

If you cannot attend this appointment, please let us know at least 24 hours in advance.

We look forward to getting to know you during the weeks and months ahead. Thank you for choosing Olympic Medical Physicians Obstetrics to care for you during your pregnancy and participate in the birth of your child. Please feel free to contact us with any questions or concerns.

Sheena Plamoottil, MD
Rose Bissonnette, MD
Emily Wallen, DO
Eleanor "Maggie" Gardner, ARNP, CNM
Jacqueline Clubine, ARNP, CNM
Brenda Woods, ARNP, CNM

Notification of No Show, Late Arrival and Late Cancellation Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions please let us know.

This notice addresses the following:

1. When patients do not show for their appointments ("no show")
2. When patients arrive past their appointment time ("late arrival")
3. When patients cancel their appointments with less than 24 hours notice ("late cancellation")

When these occur, there is a significant negative impact on our practice and on our ability to provide quality timely care to our patients. These occurrences can negatively impact that patient's healthcare, take away time that could be spent with other patients, and increase wait times for the practice.

How to avoid No Shows, Late Arrivals and Late Cancellations:

1. Confirm your appointment – use our Text Messaging service for automatic updates (ask your registrar for information)
2. Arrive at your confirmed arrival time (this is often a few minutes prior to your appointment time to give our staff time to update your records and complete your arrival)
3. Give 24 hrs notice for any appointment cancellations.

Consequences to No Shows, Late Arrivals and Late Cancellations

1. You will receive a phone call, or a letter, letting you know we missed you at your appointment time.
2. You will be offered a re-scheduled appointment, but your wait time may be longer.
3. If you miss three or more of your appointments, you may be dismissed from our practice.

I have read and understand the Olympic Medical Physicians No Show, Late Arrival and Late Cancellation notice.

_____ _____

Signature of Patient or Patient's Authorized Representative **Date**

Patient Name (Printed):_____

Date of Birth:_____ OMP22089 1/11/2021

OLYMPIC MEDICAL CENTER

Registration and Update Form (Confidential)

- Please complete all ➢ **Required sections** of this form.
- Provide an **Insurance Card** and **Photo ID** for copying.
- If you have any questions or concerns, please ask for assistance.

* Providing ethnicity, race, preferred language, disability, gender identity, and sexual orientation information is voluntary.

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➢ Patient Information

Legal Name; First:_____ **Middle**:_____ **Last**:_____

Preferred Name:_____ **Pronouns**:_____

Social Security #:_____ **Sex** (assigned at birth):_____ **Date of Birth**:_____

Mailing Address:_____

City:_____ **State**:_____ **Zip**:_____

Phone (Mark the best) ☐ Home:_____ ☐ Work:_____

☐ Mobile:_____ ☐ Message:_____

E-mail:_____

➢ General

Language: ☐ Needs Interpreter, If yes; Language:_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widow ☐Legally Separated ☐Domestic Partner ☐Significant Other

☐ Decline to respond ***Disability:** ☐ Deaf ☐ Hard of Hearing ☐ Blind ☐ Low Vision ☐ Speech impaired

☐ Decline to respond ***Religion**:_____

☐ Decline to respond ***Ethnicity/Race**: ☐White ☐Mexican ☐Puerto Rican ☐American Indian ☐Alaskan Native ☐Asian ☐Cuban ☐Black/African American ☐Native Hawaiian ☐Pacific Islander Other:_____

☐ Decline to respond ***Gender Identity**: ☐ Male ☐ Female Other please specify:_____

☐ Decline to respond ***Sexual Orientation**: ☐ Straight ☐ Gay ☐ Lesbian ☐ Queer ☐ Bisexual ☐ Pansexual ☐ Asexual ☐ Unknown Sexual orientation not listed above, please specify:_____

Employer:_____ Employment Status: ☐ Part Time ☐ Full Time

☐ Never Employed ☐ Not Employed ☐ Active Military Duty ☐ Disabled ☐ Retired ☐ Self Employed

☐ Student Full Time ☐ Student Part Time

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Phone_____

➢ Primary Care Provider (Doctor, Nurse Practitioner, Physicians Assistant, etc.)

Name:_____ Phone:_____

➢ Patient Emergency Contacts - At least 1 immediate family member

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

➢ Financially Responsible Party (Guarantor) (Complete if Guarantor is the parent or anyone other than the patient)

Guarantor Name:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Social Security #:_____ Sex:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Employer:_____ Employment Status: ☐ Part Time ☐ Full Time

☐ Never Employed ☐ Not Employed ☐ Active Military Duty ☐ Disabled ☐ Retired ☐ Self Employed

☐ Student Full Time ☐ Student Part Time

Employer Address:_____ City:_____ State:_____ Zip:_____

Occupation:_____ Phone:_____

➢ Coverage Information

Primary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship:_____

Secondary Insurance:_____ Subscriber ID:_____ Group #:_____

Subscriber Name:_____ Date of Birth_____ Relationship_____

➢ Advanced Directives

Do you have any Advanced Directives? ☐ Yes ☐ No

Last Name: _____ First Name: _____ Date of Birth: _____

By providing the following information, you enable us to give quality care that meets your unique needs. Your answers to these questions are confidential, but will become a part of your medical record.

OLYMPIC MEDICAL PHYSICIANS
Women's Health

DATING INFORMATION

What was the first day of your last menstrual period? _____ ❑ Certain ❑ Approximate

Do you have regular cycles? ❑ Yes ❑ No, please describe: _____

Is this a planned pregnancy? ❑ Yes ❑ No

Were you using birth control / contraception when you became pregnant? ❑ Yes ❑ No

OBSTETRICAL HISTORY

Please list your pregnancies in chronological order.

Date	Type: vaginal delivery, c-section, vacuum, miscarriage or abortion	Length of Pregnancy (weeks)	Length of Labor (hours)	Weight	Sex	Type of Pain control	Complications? Ex: preeclampsia, gestational diabetes, other…

MEDICATIONS

What is the name of your preferred pharmacy? _____

Please list any medications you have taken since conceiving, including vitamins and supplements

Medication	**Date Started**	**Dose**	**Frequency**	**Reason for taking**

ALLERGIES

Please list all Medications, Foods and Environmental Factors to which you react

What caused the allergy?	**Reaction**

Last Name: _____ First Name: _____ Date of Birth: _____

VACCINE HISTORY

Please check if you have had the following:

Routine childhood vaccinations	❑ Yes ❑ No ❑ Not sure			
Varicella	❑ Yes ❑ No	Or chicken pox? ❑ Yes, year:		❑ No
Current flu vaccine	❑ Yes ❑ No			
Covid vaccine	Dose 1:	Dose 2:	Dose 3:	Dose 4:

MEDICAL HISTORY

When was your last pap smear?_____ Where was this done? _____

Pre-Pregnancy Weight:_____

Please note any of the following that pertain to your personal history

Year	Medical Problem / Diagnosis	Details of Condition and Treatment
	Abnormal Pap	
	Anemia	
	Anesthetic complications	
	Asthma	
	Arthritis	
	Blood or clotting disorder	
	Blood transfusion	
	Breast problems or surgery	
	Cancer	
	Diabetes	
	Drug or Alcohol use requiring treatment	
	Gynecologic problems (fibroids, endometriosis, etc.)	
	Heart Problems	
	Herpes or a partner with Herpes	
	HIV/AIDS	
	High blood pressure	
	Infertility	
	IV drug use	
	Kidney or urinary tract problems	
	Liver disease (including hepatitis)	
	Lupus	
	Mental health problems	
	Migraines	
	Postpartum Depression	
	Rashes or skin problems	
	Seizures	
	Sexually transmitted infection (chlamydia, gonorrhea)	
	Thyroid disease	
	Trauma / violence / abuse	
	Tuberculosis or TB exposure	
*****	**Illness or infection during this pregnancy (Covid, viral rash, UTI, etc…)**	

Last Name: _____ First Name: _____ Date of Birth: _____

SURGICAL HISTORY

Year	Reason for Hospitalization and/or type of Operation	Hospital and Location

FAMILY HISTORY

Adopted: ❑ No ❑ Yes Family history unknown: ❑ No ❑ Yes

Please mark if you have any relatives with the following:

Relative	Living or Deceased	Rheumatoid Arthritis	Asthma	Breast Cancer	Other Cancer	Diabetes	Heart Failure	High Blood Pressure	Preeclampsia	Migraines	Rashes / Skin Problem	Seizures	Stroke	Thyroid Disease	Blood Clots
Mother															
Father															
Sister															
Brother															
MGM*															
MGF															
PGM															
PGF															

* Key: MGM = Maternal (mother's side) Grandmother MGF = Maternal Grandfather
PGM = Paternal (father's side) Grandmother PGF = Paternal Grandfather

GENETIC SCREENING

Have you had either of the following carrier screens:

- Cystic Fibrosis (CF) ❑ No ❑ Yes and tested negative ❑ Yes and tested positive ❑ Not sure
- Spinal Muscular Atrophy (SMA) ❑ No ❑ Yes and tested negative ❑ Yes and tested positive ❑ Not sure

Please mark all ethnicities that apply:

	Caucasian	Native American	Ashkenazi Jewish	French Canadian	African America, African or Black	Hispanic or Latino	Pacific Islander	Asian	Eastern European (Italian, Greek)	Middle Eastern	Other:
You											
Father of the Baby											

Please describe any family history of any of the following:

Condition	You	Father of the Baby
Blood disorder (Thalassemia, Hemophilia, Sickle Cell)		
Congenital Heart Defect		
Down Syndrome		
Other birth defect or inherited condition:		

Last Name: _____ First Name: _____ Date of Birth: _____

SOCIAL SCREENING

1. Who is the father of your baby? _____
2. What is your relationship with the father of your baby? _____
3. Are any of your children in the custody of someone else? ❑ No ❑ Yes

   If **YES**, please explain: _____
4. Where do you work and what do you do? _____
5. Where does your partner work and what does he/she do? _____
6. Who do you live with? _____
7. With whom are you sexually active? ❑ Male(s) ❑ Female(s) ❑ Both
8. Do you feel safe in your current relationship? ❑ Yes ❑ No _____
9. Have you ever been hit, slapped, physically hurt or threatened by a partner? ❑ No ❑ Yes

   _____
10. Is anyone in your life misusing your money or property? ❑ No ❑ Yes

Please note any past or present substance use:

Substance	Daily use? (# per day)	Weekly use? (# per week)	Former use? (Note quit date)	Length of use (# of years)
Cigarettes				
E-Cigarettes				
Second-Hand Smoke				
Chewing Tobacco				
Alcohol				
Sleep Medications				
Narcotic Pain Medications (opioids)				
Anxiety Medications				
Marijuana				
Crack or Cocaine				
Methamphetamine				
Heroin or Methadone				
Fentanyl				
Other:				

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

OLYMPIC MEDICAL CENTER

Authorization To Verbally Disclose Protected Health Information (Verbal Release - ROI)

This authorization allows us to verbally share your Medical Information as indicated below.

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Olympic Medical Center • Olympic Medical Physicians • Olympic Medical Home Health

Olympic Medical Center realizes that there may be times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. If so, your authorization allows staff to speak with the individual(s) you designate below.

PATIENT INFORMATION:

Patient Name (printed):_____ Previous Name (if any):_____

Date of Birth:_____ Daytime Telephone Number:_____

INFORMATION TO BE DISCLOSED FROM:

I hereby authorize Olympic Medical Center to verbally disclose the following information contained in my medical record and/or information regarding my medical care or condition as described below.

GENERAL INFORMATION TO BE DISCLOSED TO PEOPLE NAMED BELOW:

- ❑ You may discuss scheduling and appointment information.
- ❑ You may discuss test results, medical condition(s) and/or current treatment.
- ❑ You may discuss billing, insurance and payment information.

INFORMATION TO BE DISCLOSED TO:

Name	Relationship to Patient	Phone Number

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the disclosure of healthcare information relating to the testing, diagnosis, or treatment for (Please initial beside the specific information to disclose):

Please Initial

_____ Drug and Alcohol Abuse / Treatment

_____ Mental Health / Psychiatric Disorders

_____ HIV / AIDS Virus

_____ Sexually Transmitted Infections

_____ Reproductive Health

CONSENT TO DISCLOSE:

By my signature below I indicate that I understand that I have the right to revoke this authorization in writing at any time. I understand that information used or disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

<u>This consent is specific to verbal disclosures only.</u> If copies of my medical records are being requested, a separate Authorization to Disclose Protected Health Information will need to be obtained.

This authorization will be valid for 90 days or until:_____

_____ _____ OR _____❑ Patient verbally agreed

Date Signature of patient or representative Witness Signature for Verbal Agreements

OLYMPIC MEDICAL CENTER

Financial Assistance Plain Language Summary

Do I qualify?
Based on your income and family size, you may qualify for a discount of 50%-100% of your bill.

In some cases, we'll evaluate criteria other than income. For example, if you experience a catastrophic event, you may qualify regardless of income.

Examples:

Individual with $24,000 income = 100% discount	Couple with $55,000 income = 50% discount	Family of four with $72,000 income = 75% discount
		

For a full list of family incomes, family sizes, and discounts, see the next page.

What does the Program cover?
The Program covers medically necessary care provided by us or by one of our providers.

How do I apply?

- **MyChart:** Under Billing select Manage Financial Assistance.
- **Online:** www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services
- **Telephone:** Call Patient Financial Services at (360) 417-7111
- **Mail:** Mail a request to Olympic Medical Center, 519 S Peabody, Port Angeles, WA 98362
- **In Person:** Visit the Patient Financial Services Department at
  519 S Peabody, Port Angeles, WA 98362
  Office hours are Monday-Friday 8:00 AM to 4:30 PM

For paper applications, mail or bring your completed application and required documentation to Olympic Medical Center, 519 S Peabody St., Port Angeles, WA 98362. We process submitted applications only once they are complete. If your application is not complete, we will notify you and provide an opportunity to send the missing documentation or information.

For a free copy of the entire Financial Assistance Policy use the Online, Telephone, Mail or In Person listings under "How do I apply".

	Olympic Medical Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Spanish Español	Olympic Medical Center cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-360-417-7000 TTY: 1-360-417-8686
Chinese 繁體中文	Olympic Medical Center 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-360-417-7000 TTY: 1-360-417-8686

2026 Charity Care Sliding Scale by Gross Annual Income			
Effective for Dates of Service on and after 1/1/2026			
Family Size	0-200% FPL **100% Discount**	201-250% FPL **75% Discount**	251-300% FPL **50% Discount**
1	$0 - $ 31,920	$ 31,921 - $ 39,900	$ 39,901 - $ 47,880
2	$0 - $ 43,280	$ 43,281 - $ 54,100	$ 54,101 - $ 64,920
3	$0 - $ 54,640	$ 54,641 - $ 68,300	$ 68,301 - $ 81,960
4	$0 - $ 66,000	$ 66,001 - $ 82,500	$ 82,501 - $ 99,000
5	$0 - $ 77,360	$ 77,361 - $ 96,700	$ 96,701 - $ 116,040
6	$0 - $ 88,720	$ 88,721 - $ 110,900	$ 110,901 - $ 133,080
7	$0 - $ 100,080	$ 100,081 - $ 125,100	$ 125,101 - $ 150,120
8	$0 - $ 111,440	$ 111,441 - $ 139,300	$ 139,301 - $ 167,160
*For families/households with more than 8 people, add $5,680 for each additional person			

Due to yearly updates to this information, there may be a more recent version.
The latest version will be posted on our website:
www.olympicmedical.org then go to Patients & Visitors, Billing & Financial Services