



Thank you for your interest in becoming a patient at Jamestown Family Health Clinic.

Complete & return this packet to the clinic, along with copies of your

Current Insurance card(s)

Photo ID (State or Passport)

Schedule your New Patient Appointment

New patient appointments are scheduled on a first come, first served basis with the next available provider

Register for MyChart

This is the Clinic preferred method of communication

You will receive your MyChart Access Code when you schedule your New Patient Appointment

Complete the MyChart Family Medicine History Questionnaire

Completing this questionnaire will ensure your chart is ready for your appointment with your new provider

Questionnaire must be filled out at least 24 hrs prior to your appointment.

Complete the MyChart Pre-Check before your New Patient Appointment

MyChart Pre-Check is available up to 4 days before your appointment

Update your medication list, pharmacy, allergies & demographics during MyChart Pre-Check

Important information for New Patients

- **Refills of controlled substances such as Opioids, benzodiazepines, or other high-risk medications will not be given during your new patient appointment.**
- If you are **unable** to keep your appointment, **please contact the clinic** at 360.683.5900 as soon as you can to reschedule.
- New patients that **no show** or **cancel appointments with less than 24 hours' notice** may not be allowed to reschedule.

What is MyChart??

MyChart is an online patient portal available on your computer or through an App allowing you to have more access to your care team through:

- **Secure messaging (all messages become part of your legal medical record)**
- **Viewing lab and imaging test results**
- **Requesting prescription renewals**
- **Updating your health history**
- **Paying your bill**
- **Schedule non urgent appointments**

When you schedule your appointment, you will receive more information on how to access and use MyChart.



PATIENT INFORMATION							
NAME: FIRST		MIDDLE			LAST		
PREVIOUS NAME(S)				PREFERRED NAME			
DATE OF BIRTH	LEGAL GENDER: FEMALE MALE		IDENTIFIED GENDER: FEMALE MALE		SOCIAL SECURITY #		
MAILING ADDRESS		CITY		STATE		ZIP	
HOME #			CELL #		WORK #		
OK TO LEAVE DETAILED MESSAGES ON VOICEMAIL? YES NO			EMAIL				
ETHNICITY (CIRCLE ONE)		HISPANIC OR LATINO		NON HISPANIC OR LATINO		DECLINE	
RACE (CIRCLE ONE)	AFRICAN AMERICAN	ASIAN	ALASKAN NATIVE / NATIVE AMERICAN	CAUCASIAN	PACIFIC ISLE	OTHER/MULTI	DECLINE
PREFERRED LANGUAGE:				INTERPRETER NEEDED		YES NO	
MARITAL STATUS (PLEASE CIRCLE)		SINGLE MARRIED		DIVORCED		WIDOWED DOMESTIC PARTNER	
EMERGENCY CONTACT: NAME				RELATIONSHIP TO PATIENT		PHONE #	
EMPLOYMENT STATUS (CIRCLE ONE)		FULL TIME		PART TIME		RETIRED OTHER _____	
EMPLOYERS NAME			ADDRESS			PHONE #	
PARTY FINANCIALLY RESPONSIBLE FOR PATIENT ACCOUNT (CIRCLE ONE)				SELF		OTHER	
IF OTHER, COMPLETE THIS SECTION:		FIRST		MIDDLE		LAST	
							RELATIONSHIP TO PATIENT
MAILING ADDRESS		CITY		STATE		ZIP	
PHONE #		SOCIAL SECURITY NUMBER		DATE OF BIRTH		EMPLOYER	
INSURANCE INFO (CIRCLE ONE)		COMMERCIAL/ GOVERNMENT INSURANCE		AUTO ACCIDENT		WORKERS COMPENSATION	
PRIMARY INSURANCE				PREFIX & ID #		GROUP #	
SUBSCRIBER NAME: (if other than patient)							
RELATIONSHIP TO PATIENT				DATE OF BIRTH		SOCIAL SECURITY #	
SECONDARY INSURANCE				PREFIX & ID #		GROUP #	
SUBSCRIBER NAME: (if other than patient)							
RELATIONSHIP TO PATIENT				DATE OF BIRTH		SOCIAL SECURITY #	

IS YOUR FAMILY MEDICAL HISTORY KNOWN?	YES									NO									IF NO, WERE YOU ADOPTED?		YES				NO			
	Relationship	Alive	Deceased	Rheumatoid arthritis	Osteoarthritis	Asthma	Cancer	Diabetes	Heart Failure	Congestive Heart Disease	High Cholesterol	Hypertension	Migraines	Rashes/skin problems	Seizures	Stroke	Thyroid Disease	Other: _____	Other: _____	Other: _____	Other: _____	Other: _____	Other: _____	Other: _____	Other: _____			
Mother																												
Father																												
Sister(s)																												
Brother(s)																												
Maternal Grandmother																												
Maternal Grandfather																												
Paternal Grandmother																												
Paternal Grandfather																												

SOCIAL HISTORY

DO YOU DRINK ALCOHOL?	YES	Not Currently	NO	IF YES, HOW MANY PER WEEK:	Wine _____	Beer _____	Shots of Liquor _____
------------------------------	-----	---------------	----	-----------------------------------	------------	------------	-----------------------

ARE YOU SEXUALLY ACTIVE?	YES	Not Currently	NO	Birth Control Method? _____	PARTNER PREFERENCE?	FEMALE	MALE	BOTH
---------------------------------	-----	---------------	----	------------------------------------	----------------------------	--------	------	------

DO YOU USE MARIJUANA?	YES	NO	DO YOU USE STREET DRUGS?	YES	NO	IF YES, WHAT KIND?	Anti-Anxiety Meds	Amphetamines		
Barbiturates	Cocaine	Heroin	Inhalants	LSD	Methamphetamines	Narcotics	Nitrous oxide	PCP	IV	Other: _____

DO YOU USE TOBACCO?	NEVER	YES	FORMER	WHEN DID YOU START USING TOBACCO? _____	HOW MANY PACKS PER DAY? _____		
IF YES, WHAT TYPE? <i>Circle all that apply</i>	CIGARETTES	CIGAR	PIPE	E-CIGARETTE	SNUFF	CHEW	IF FORMER, WHAT YEAR DID YOU QUIT? _____

ARE YOU CURRENTLY PREGNANT?	YES	NO	HAVE YOU EVER BEEN PREGNANT?	NO	YES	IF YES, HOW MANY TIMES? _____	# OF LIVE BIRTHS _____
------------------------------------	-----	----	-------------------------------------	----	-----	--------------------------------------	-------------------------------



JAMESTOWN
FAMILY HEALTH CLINIC

A note to prospective patients of Jamestown Family Health Clinic who are prescribed opioid pain medications, from their current or past healthcare providers.

We are pleased that you have chosen to seek care at JFHC. Fully understanding, anticipating, and planning for your initial visit is the best way to ensure you experience a seamless, safe, and satisfactory transition in your care.

Establishing primary care at JFHC is not a guarantee that we will continue to prescribe medications in the same manner or dosing as your previous healthcare providers. The continued use of opioid pain medications, in the treatment of chronic pain conditions, first requires a comprehensive evaluation by your JFHC provider. Your initial visit, related to chronic pain management, includes a complete review of past medical, surgical, medication, social, family, drug, and alcohol use histories, along with an appropriate pain focused physical examination.

During your first or subsequent visit to JFHC, your provider will review your medication list in the context of your whole patient care at JFHC. We are a Family Medicine Clinic and do not offer Pain Specialty services separate from our patient's primary care needs. Patients for whom opioid pain management is their primary healthcare need may be directed to seek care at a specialty clinic.

For JFHC to provide appropriate and safe chronic pain management, new patients are required to supply JFHC with outside records pertinent to your pain management history. This includes chart notes, treatment plans, and any imaging reports (x-rays, MRIs, CT scans, other) previously obtained in the evaluation of your pain conditions. For any records, not readily available in our Epic electronic health record, you will need to complete Release of Information forms, available at our front desk.

Consideration for refills of your current opioid pain medications is contingent upon your JFHC provider having full access to such records prior to or at the time of your initial visit. To avoid a possible disruption in your pain management regimen, please take the time to ensure your records are available to us at the time of your first visit.

Thank you for choosing JFHC for your ongoing primary healthcare needs.

Paul Cunningham, MD
Chief Medical Officer, JFHC



Jamestown Family Health Clinic is a family practice clinic that offers pain management services to our patients on a case-by-case basis. To be considered for pain management, you will be required to complete an Initial Chronic Opioid Therapy packet and provide medical records from any healthcare provider that has treated your chronic pain. Once you return your packet, it will be reviewed along with your previous medical records to determine if you are an appropriate candidate for chronic pain management at our clinic. If your case is complex, we may refer you to a specialty pain clinic or advise that you remain with your current pain management provider. It is important for you to maintain care with your current pain management team until your case has been reviewed and accepted.

Are you currently prescribed opioid medications? Yes No
Will you be requesting pain management services at Jamestown? Yes No
Have you ever seen a pain specialist? Yes No

If you have records with a pain specialist, please complete records release below.

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Previous Name _____

INFORMATION TO BE RELEASED FROM:

Organization/Provider

Mailing Address City St ZIP

Phone Fax

INFORMATION TO BE RELEASED TO:

Jamestown Family Health Clinic
808 N. 5th Ave, Sequim, WA 98382
PH: 360-683-5900 FAX: 360-582-4800

PLEASE DO NOT SEND RUN-ON RECORDS
OR RECORDS PRINTED FRONT & BACK

INFORMATION TO BE RELEASED:

Last two years' worth of all medical records: Records to include psychiatric disorders/mental health, drug and/or alcohol use and treatment.

To EXCLUDE any of the following information, INITIAL all that apply:

_____ Mental Health or Psychiatric Disorder _____ STD or STI (Sexually transmitted disease or infection)
_____ Drug and/or Alcohol abuse and Treatment _____ HIV/AIDS Virus

PURPOSE OF RELEASE: Continuing Care Transfer of Care

Patient Notice: I understand that if the recipient of the information disclosed under this authorization is not a health plan or provider covered by federal and state privacy laws, the information may be re-disclosed by the recipient and no longer protected by those laws. If the information being disclosed under this authorization includes chronic pain management, mental health, and drug/alcohol abuse diagnosis, treatment or referral information, federal law and regulation including 42 CFR Part 2 and 45 CFR Parts 160 and 164 or state law may prevent the recipient from disclosing this information.

I understand that I do not have to sign this authorization to get health care benefits. However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing to Jamestown Family Health Clinic Attn: Administration. If I did, it would not affect any actions already taken based upon this authorization.

Signature of Patient or Legally Responsible party

DATE (MM/DD/YYYY)

Relationship to patient, if not signed by patient

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name: _____

Date of Birth: _____

My signature below gives permission to the person(s) listed to receive limited information about my care. I understand my healthcare provider will use their professional judgement to ensure that information is shared with my family/friends in order to assist with my continuing care. This form replaces any previously signed PHI at Jamestown Family Health Clinic and should be considered ongoing until I state otherwise in writing.

NAME & RELATIONSHIP TO PATIENT	PHONE NUMBER	WHAT IS ALLOWED TO BE DISCLOSED (E.g. Discuss health, pick up RX, test results, etc.)	OK TO LEAVE DETAILED MESSAGE?	
			Yes	No

No Show/Late Cancellation Policy

- As a new patient to Jamestown Family Health Clinic if you, No Show or Cancel your first appointment with less than 24 hours' notice (Late Cancel) we reserve the right to not schedule another new patient appointment.
- Established patients of Jamestown Family Health Clinic if you No Show/Late Cancel 3 or more we reserve the right to discharge you as a patient and not schedule you for any further appointments with our clinic.
- We ask that you give 24-hour notice for cancellation of all scheduled appointments.

Medication Renewal Policy*

- It is your responsibility to plan ahead so you do not run out of medications as this can be dangerous to your health.
- Please allow up to 72 hours for us to process all renewal requests
- For all new problems, please make an appointment to see your provider or care team member
- For **ALL** controlled substances, you must make an appointment with your provider for a renewal

**Please read the complete Medication Renewal Policy in the Patient's Rights, Responsibilities, and Policies booklet.*

I have read the above policies and have been given a copy of the Patient's Rights, Responsibilities, and Policies. I understand even if I decline to sign and/or accept a copy of the Patient's Rights, Responsibilities, and Policies I am still required to follow ALL Clinic policies.

Patient or legal representative signature

Date

Printed name of legal representative (If signed by someone other than patient)

