819 E Georgiana St. Port Angeles, WA 98362
Phone: 360-457-4431 Fax: 360-457-7755
info@opcclinic.org

Welcome to Olympic Peninsula Community Clinic

Please note that almost ALL of the people you see here working at OPCC are volunteers and do not receive compensation for their time. We want you to feel cared about when you are here. Please be kind to everyone here, as each one of us is doing their best to help you stay well.

OPCC Does NOT Prescribe:
- Medical Marijuana
- Narcotics

Please Notify OPCC if any of the following occurs:
- Change in Pharmacy
- Change in Address
- Change in Phone Number
- Change in Insurance
- Change of Primary Care Provider

No Show/15 minutes Late Policy

1. You may be counted as a **No Show** if you:
   - Do not come in to an appointment
   - Cancel the day of an appointment
   - Leave before your appointment
   - Arrive more than 15 minutes late to an appointment

2. If you arrive more than 15 minutes late to an appointment you may need to reschedule to be seen.

3. Please call us **at least 24 hours** before your appointment time if you need to cancel.
This allows other community members to be seen by our providers if you are unable to come in.

Medication Refills

1. If you are also receiving medications somewhere other than OPCC, with the exception of a prescription written from an Emergency Room visit, we may discontinue refills for your medications.

2. When picking up a last refill on a medication, please call and ask your pharmacy to send us a refill request and call us to schedule an appointment.

If you have not been seen in a year or longer, OPCC will withhold refilling prescriptions until you make an appointment with us. You will be notified once we receive a refill request from your pharmacy and the provider has informed us that they would like to see you. **Failure to make or come to this appointment may result in further delay of your medications.**

OPCC does not charge fees for office visits, however, we ask that patients donate as they are able. Also, many diagnostic tests, outside procedures, and referrals are NOT free. It is your responsibility to inquire ahead of time about fees.

By signing this form, you acknowledge that you have read and understand the above and agree to notify OPCC of any changes listed above.

Signature _____ Date _____

NOTICE:

Olympic Peninsula Community Clinic (OPCC) does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, gender identity, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities.

New Patient Intake Form

Please answer all questions as accurately as possible. Thank you!

Please have reception make a copy of your insurance card and ID when turning in this packet.

First Name (Please Print) **MI** **Last Name (Please Print)** **Preferred Name**

Social Security Number | Date of Birth | F / M / NB Gender | He/Him - She/Her - They/Them Sexual Identity/Preferred Pronouns

Preferred Method of Contact: Cell Phone – Home Phone – Email – Text

Cell Phone | Home Phone | Email

Street Address | Apt/Trlr | City | State | Zip Code

Do You Have Health Insurance? Yes / No

Do you have any of the following coverage options (Please circle all that apply):

Medicare: Part A Part B Part C Part D Medicare Advantage Plan

Medicaid: Wellpoint Molina United Healthcare Coordinated Care of WA

Coverage without a Managed Care Plan

Other (Please Specify):_____

Were you referred to us by any of the following (Please Circle): N/A

Olympic Medical Center OMC Walk-In Clinic Peninsula Behavioral Health

Friend/Family TAFY North Olympic Healthcare Network

What services are you requesting through OPCC? Medical Dental Counseling

Have You Received Your (Please circle): High School Diploma GED N/A

Would you have gone to the Emergency Room if OPCC was not here? Yes / No

When was your last medical or dental appointment? _____

Have you ever been treated by a mental health professional? Yes / No

Do you smoke tobacco? Yes / No **How old were you when you started?** _____

How much do you smoke a day? _____ (packs) **Do you use vape products?** Yes / No

How often do you drink alcohol? _____ **How much do you drink?** _____

Have you ever tried any non-prescription substances, even if it was only once? Yes / No

If yes, which substances did you take? _____

Were any used intravenously (IV)? Yes / No

If you are in recovery, how long have you been free from use? _____

Do you need any support in staying sober? Please let us know what we can do to help.

_____

How much exercise do you get daily? _____

What activities do you participate in? _____

What does your diet consist of? _____

Have you ever been tested for: Hepatitis C HIV/AIDS Neither

If yes, was your result positive? Yes / No **Have you received treatment?** _____

Do you feel safe at home? Yes / No **Are you being abused at home?** Yes / No

Do you need help finding housing? Yes / No

Have any of your utilities been shut off? Yes / No

If yes, which utility and how long? _____

Do you need help paying for food? Yes / No

Are you (please circle all that apply): Homeless At Risk of Homelessness Couch Surfing

Are you from Clallam County? If no, what is your county of origin? _____

Are you here (Please circle):

Temporarily Just Moved Here Thinking About Moving Here

How long have you been in the area? _____

Olympic Peninsula Community Clinic

Health History OPCC

Your dental health can an impact all of your other systems. It is important to answer all questions as accurately as possible so we can provide you with quality services. Thank you.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation in the past 2 years?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you have dental pain? Please rate on a scale of 1-10, with a 10 being incredibly severe pain.	◯ Yes ◯ No	If yes
If yes to pain, does this pain come and go, or is it consistent?	◯ Yes ◯ No	If yes
Have you had to take antibiotics for a dental infection?	◯ Yes ◯ No	
If yes, how many times did you have to take them?	◯ Yes ◯ No	If yes
Do you have dental anxiety?	◯ Yes ◯ No	
If yes, do you take medication before being seen at the dentist to help?	◯ Yes ◯ No	If yes
If so, who prescribes the medication for you?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No				

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

If you have had cancer, have you

Completed Treatment	◯ Yes ◯ No	Started Treatment	◯ Yes ◯ No
Had Chemotherapy	◯ Yes ◯ No	Decided to not seek treatment	◯ Yes ◯ No
Had reoccurring Instances of disease	◯ Yes ◯ No	Had a bone marrow transplant	◯ Yes ◯ No

Has anyone in your family had any of the following conditions?

Cancer	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No
Heart Conditions	◯ Yes ◯ No	Mental Health Diagnosis	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Opiod or Alcohol Addiction	◯ Yes ◯ No	Hepatits	◯ Yes ◯ No

If yes, what family member(s) had these conditions? ◯ Yes ◯ No If yes

Is there anything else we need to know about your health conditions? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date: _____

Pharmacy: ____________________

Medication Name	Dose	Directions	Need Refills Soon?

Allergies: **(Please list all Allergies for Medications, Environment, and Food)**

Allergen	Reaction	How Severe	Onset of Allergy

Emergency Contact (In case of an emergency, I would like OPCC to contact):

Name of Individual	Contact Number	Relationship to Patient
Name of Individual	Contact Number	Relationship to Patient

During the past 12 months, have you (please check all that apply):

Become restless irritable or anxious when trying to stop/cut down on gambling?	
Tried to keep your family or friends from knowing how much you gambled?	
Had such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or government assistance?	

Adult ADHD Self-Report Scale Symptom Checklist (ASRS-v1.1)

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organisation?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15.How often do you find yourself talking too much when you are in social situations?					
16.When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish themselves?					
17. How often do you have difficulty waiting your turn in situations when turn-taking is required?					
18. How often do you interrupt others when they are busy?					

PHQ- 9

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
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
				PHQ9 Total Score	

GAD-7

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
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
				GAD7 Total Score	

Authorization to Disclose Protected Health Information

Olympic Peninsula Community Clinic
Phone: 360-457-4431 **Fax**: 360-457-7755

Patient Information:
Patient Name (Printed):_____

Previous Name(s):_____

Date of Birth: _____ Daytime Telephone Number:_____

SEND INFORMATION TO: (Please be Specific)
Provider Name/Organization: **OLYMPIC PENINSULA COMMUNITY CLINIC&REDISCOVERY PROGRAM**
Address: **819 GEORGIANA ST / P.O. BOX 639**
City: **Port Angeles** State: **WA** Zip Code: **98362**
Main Line: **360-457-4431** Fax: **360-457-7755**

INFORMATION TO BE RELEASED FROM: (Please be specific)
Provider Name/Organization:_____

Address: _____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Fax Number_____

PURPOSE OF DISCLOSURE
○Transfer of Care ○ Self ○ Specialist ○ Other_____

INFORMATION TO BE DISCLOSED
○Medical Information from the last two years
○Limited Health Information of Documentation Dates of Service: _____
○Complete Medical Chart Contents
○Other_____ Expiration Date (or event): _____

CONSENT TO DISCLOSE
If the patient is unable to sign, please indicate such and the authority to act of the person who is signing for the patient. **This form must be dated** within 90 days of receipt and may be revoked at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization. We will not condition treatment on the completion of the authorization. Also, please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA 1996. **If no expiration date or event is specified this form is valid for 1 year after the date of signing.**

BY SIGNING THIS RELEASE I UNDERSTAND THAT:
The provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The recipient may not be subject to Federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a patient in a Federally assisted alcohol or drug abuse program, the Recipient is prohibited under Federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the patient or as otherwise permitted under Federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2)
I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from OPCC.
I may revoke this Authorization at any time, and it will not take effect on any action taken by the provider that is reliant on this Authorization before the provider receives written notice of revocation.
A minor client's signature is required in order to release information concerning care for behavioral/mental health conditions and/or alcohol/drug use issues, and in order to release information regarding pregnancy and/or termination, sterilization and sexually transmitted diseases.

DISCLOSURES REQUIRING SPECIAL CONSENT
My signature below specifically authorizes the **exclusion** of healthcare information relating to the testing, diagnosis, or treatment for **(Please initial beside the specific information to exclude)**

_____HIV/AIDS Virus _____Mental Health/Psychiatric Disorders
_____Sexually _____Drug/Alcohol Use

_____ _____ _____
Date Signature of patient or representative Relationship to patient

Authorization to Discuss Medical Information

I hereby authorize to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

___Appointment Dates and Times ___Diagnosis ___X-ray Results ___Medications

___Lab Tests/Results ___Summary of Medical Record ____Care Plan

___Other (Please Specify):_____

Please Initial Which Confidential Information :

_____Mental Health _____HIV Information _____Alcohol/Drug Information

Patient Name:_____ DOB:_____

Information to be given to:
Name:_____ Relationship to Patient_____

Address:_____ Phone:_____

This Authorization shall remain in effect from the date signed below until (Please check one):
___ _____(Specify Expiration Date or Event)

___ No Expiration Date

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the main office.
- This authorization is giving the Olympic Peninsula Community Clinic the right to discuss my medical information with one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature:_____ Date:_____

Relationship to Patient (If signed by personal representative):_____

Notice of Privacy Practices

Your Rights

Get a paper copy of your medical record, and a copy of this privacy notice. Ask us to see or get a copy or summary of your health information. You can also ask for a copy of this privacy notice. We will provide you with a paper copy promptly.

Ask us to correct your medical record. You can ask us to correct health information that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us *not* to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority before we take any action.

File a complaint if you feel your rights are violated. You can complain to us. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue SW, Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes or sale of your information
- Most sharing of psychotherapy notes.

Our Uses and Disclosures

We typically use or share your health information to:

Treat you. We can use your health information and share it with other professionals who are treating you.

Run our organization. We can use or share your information to run our practice, improve your care, and contact you when necessary.

Bill for your services. We can use or share your information to bill and get payment from health plans.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues. We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety.

Do research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director, when an individual dies.

Address government requests. We can use or share health information about you:

- For workers' compensation.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to **maintain the privacy and security** of your protected health information.

We **will let you know promptly if a breach occurs** that may have compromised the privacy or security of your information.

We must **follow the privacy practices described** in this notice and give you a copy of it.

We will **not use or share your information other than as described here** unless you tell us we can in writing. We you tell us we can, you can let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We **can change the terms of this notice**, and the changes will apply to all information we have about you. The new notice will be available upon request and in our office.

I have received and read OPCC's Notice of Privacy Practices.

Signature _____ Date _____

VERIFICATION OF QUALIFICATION FOR FINANCIAL ASSISTANCE*

It is my understanding that Olympic Medical Center (OMC) has an agreement with the Olympic Peninsula Community Clinic (OPCC) in Port Angeles to provide diagnostic imaging and lab services at no charge to OPCC patients who meet the financial assistance guidelines stated in the chart below – the 2026 Federal Poverty Guidelines.

It is also my understanding that, if I have insurance coverage, Olympic Medical Center will bill my insurance carrier for services. Any balance due on my account after the insurance payment is received will be billed to me by OMC. It will be my obligation to mail or deliver the bill to OPCC if I wish the amount to be transferred from my account to OPCC's account. Otherwise, I will be responsible for any remaining balance due to OMC.

I, **(PRINT NAME)** _____, verify that I qualify for financial assistance based on the number of members in my household and my monthly/annual household income, as checked below.

2026 Poverty Guidelines	
Person(s) in Family/Household	Two Times the Poverty Guideline Income Level
1	$31,300
2	$42,300
3	$53,300
4	$64,300
5	$75,300
6	$86,300
7	$97,300
For families/households with more than 7 persons, add $5,500 for each additional person.	

Printed Patient Name:_____

Signature:_____ Date:_____

**This form is not required to receive services from OPCC providers or programs.*

Technology Agreement

The Olympic Peninsula Community Clinic utilizes developing technology when serving our patients. This includes the use of HIPAA compliant software which helps transcribe office visit notes for providers, and telehealth visits over Zoom.

I, (Full Name) _____ acknowledge that any information gathered from the use of telemedicine or AI transcription services is subject to all protections of the HIPAA Act and will not be disclosed to any outside agency without my authorization. Any information will be used for the purpose of documenting my visit only. All recordings will be destroyed upon the completion of my chart note.

By signing this form below, I agree to and understand the following:

- Voice and video recordings may be captured and stored for up to 29 days for documentation purposes.
- All information collected is only to be used for OPCC chart notes.
- My information is protected by HIPAA and is held to the standards of the Olympic Peninsula Community Clinic's Privacy Policy.
- I can revoke this authorization at any time, in writing.

This authorization is valid until I either end my relationship with OPCC or revoke it in writing.

_____	_____	_____
Name, please print	Signature	Date