

## ***Woodstock Family Medicine Financial Policy***

The following financial policies have been designed to enable **Woodstock Family Medicine** to continue providing quality patient care in a cost effective manner.

Any insurance deductible amounts and non-covered services will be your responsibility. If you have any questions about the payments made by your insurer, please feel free to discuss them with our Billing Office or contact your insurer directly. **Statements are mailed out monthly and payment is due within 30 days.** Monthly statements will follow until the account is paid in full. If you have not paid your portion of the bill, or have not set up a monthly payment plan you will receive a Final Notice or Last Chance letter notifying you that your account is in jeopardy of being turned over to Collections. If the bill is not paid within the time indicated in the letter, we will have no choice but to turn the account over to a collection agency. Collection activity could impact your credit scores.

If you have questions about insurance benefits, your account, or our financial policy, please call our billing specialist who will work with you to offer personalized service to resolve billing and collection issues. **Questions: (503) 236-1830.**

### **Credit**

Woodstock Family Medicine welcomes you as a new/established patient. The following information explains our Credit Policy. Please read, sign and return to the receptionist. If you have any questions regarding any part of these policies, please do not hesitate to ask for assistance.

1. **Self Paying patients are required to make payment at time of service.**
2. Self paying patients are offered a cash discount when payment in full is made at the time of service. Ask for details.
3. Balances not covered by insurance are due within 30 days of your statement billing unless satisfactory arrangements have been made with the business office.
4. For your convenience, we bill primary and secondary insurance; however, you are responsible for paying all account balances in a timely manner regardless of discrepancies and/or disputes you may have with your insurance carrier.
5. If your medical charges exceed the annual maximum established by your insurance carrier the balance (not covered by your insurer) is your responsibility. Always call your insurer to verify your current benefits.
6. If your insurance plan requires a co-payment from you, we will collect this at the time of your visit. **CO-PAYMENTS ARE DUE AT TIME OF SERVICE.** If your co-payment is not made at time of service, you will incur a \$5.00 billing fee.
7. The parent or guardian with whom a minor child lives with will be considered the responsible party for the payment of the charges incurred at this facility regardless of circumstances involving, divorce, custody, etc.

We accept Cash, Checks (except new patients), VISA, Mastercard and debit cards. As an added convenience, we can accept credit card or debit payments via the telephone. There is a \$35.00 surcharge for any check returned for non-sufficient funds.

### **After hours**

**After hours paging is for emergencies only.** Non-emergency pages (ie. refill requests, questions that can wait until the next business day) will be charged a fee of **\$50.00**.

### **Cancellation Policy and Procedures**

It is our policy to require 24 hour notice on all cancellations. If a patient fails to cancel 24 hours prior to the appointment, the patient is responsible for a missed appointment charge. There is a \$35.00 charge for a missed scheduled appointments, and a \$100.00 charge for a missed appointment for preventive care not cancelled within 24 hours. Please call us during our regular business hours to cancel or reschedule appointments.

After 3 consecutive “no show” appointments, the patient must bring their account current, including the “no show” fees, before scheduling another appointment.

**CONTINUED ON OTHER SIDE**

**Insurance Plans**

We participate in a variety of Preferred Provider Organizations. It is the patient’s responsibility to check with their insurer and confirm we are participating in their plan. When changing insurance plans, we also suggest you also check with our billing department to make sure we have not changed our participation status with your plan.

**Workers Compensation and Motor vehicle claims**

We do **not** accept any new workers compensation claims or motor vehicle claims. You will be referred out for these services.

**Completion of Forms and Reports**

Completion of FMLA forms, disability forms etc. will incur a **\$35.00 fee** payable at the time of completion. Completion of these forms during an appointment specifically for this purpose is included in the appointment fee.

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**FINANCIAL AGREEMENT**

*The undersigned agrees that in consideration of services to be rendered to the patient, he/she assumes financial responsibility for this account under the terms and conditions listed above. Persistently delinquent accounts will be referred to an independent collection agency or small claims court, in which case you will assume the full responsibility for collection costs, including attorney and/or court fees.*

**I/we hereby** authorize the insurer named on the “Patient Information Form” to pay directly to Woodstock Family Medicine, in accordance with the billing, any benefits which may apply under their policies, and hereby irrevocable assign such benefits to Woodstock Family Medicine, to the extent of such billing.

**I/we hereby** authorize the release of any and all medical information required by any insurer in connection with processing any requests for benefits to which I may be entitled, and you are authorized to make such requests on behalf. I understand that information protected by state and federal law may be requested, and I specifically consent to the release of such protected information, including/excluding information regarding treatment of HIV or mental health or chemical dependency conditions.

I have read and understand the above credit and release of information policies.

\_\_\_\_\_  
Patient’s signature (Parent or guardian if patient is a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient’s Full Name

# Woodstock Family Medicine

Melanie J. Smythe, D.O.

Jerrold L. Snow, D.O.

5536 SE Woodstock Blvd  
Portland, Oregon 97206  
503 236-1830 Fax: 503 236-1908

## AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

By **initialing** the spaces below, I, \_\_\_\_\_ DOB; \_\_\_\_\_ hereby authorize, **Woodstock Family Medicine** to release information to: \_\_\_\_\_ obtain information from: \_\_\_\_\_ (or) exchange information verbally with: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Street: \_\_\_\_\_ Fax: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

The information will be used on my behalf for the following purpose(s): \_\_\_\_\_

By **initialing** the spaces below, I specifically authorize the release of the following medical records if they exist.

- |                                                                        |                                                                            |
|------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Medical records needed for continuity of care | <input type="checkbox"/> Gynecologic history, exams and Pap smears results |
| <input type="checkbox"/> Clinic office chart notes                     | <input type="checkbox"/> Contraception records                             |
| <input type="checkbox"/> Emergency and Urgent care records             | <input type="checkbox"/> Physical therapy records                          |
| <input type="checkbox"/> Laboratory reports                            | <input type="checkbox"/> All Hospital records                              |
| <input type="checkbox"/> Diagnostic imaging reports                    | <input type="checkbox"/> Pathology reports                                 |
| <input type="checkbox"/> Medication records                            | <input type="checkbox"/> Most recent 5 years                               |
| <input type="checkbox"/> Billing statements                            | <input type="checkbox"/> Other _____                                       |

\_\_\_\_\_ Please send the **entire medical record** (all the above information, plus any initialed below. The undersigned patient agrees this record may be voluminous and agrees to pay all reasonable fees associated with providing this information.

\_\_\_\_\_ **HIV/AIDS** related records (*must be initialed to be included in other document.*)

\_\_\_\_\_ **Mental Health** information which includes depression (*must be initialed to be included in other documents*)

\_\_\_\_\_ **Genetic** testing information (*must be initialed to be included in other documents*)

\_\_\_\_\_ **Drug/Alcohol** diagnosis, treatment or referral information (*Federal Regulations, 42CFR Part 2, requires a description of how much and what kind of information is to be disclosed.*) \_\_\_\_\_  
(be specific)

\_\_\_\_\_ This authorization is limited to the following **treatment**: \_\_\_\_\_  
(be specific)

\_\_\_\_\_ This authorization is limited to **workers' compensation** claim for injuries of (date). \_\_\_\_\_  
(be specific)

\_\_\_\_\_ This authorization is limited to the following **time period**: \_\_\_\_\_  
(be specific)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. These records **may / may not** be sent by fax.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or person authorized by law

# Woodstock Family Medicine

## REGISTRATION FORM

### Patient Information - Please Print Clearly

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Circle Gender: M F SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Required unless paying Cash at time of service)

Home # \_\_\_\_\_ Work# \_\_\_\_\_ Employer: \_\_\_\_\_

Circle appropriate status: Minor Single Married Divorced Separated Widowed

### Primary Insurance Information – Please give insurance card to receptionist to copy

Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscribers date of birth: \_\_\_\_\_

ID: \_\_\_\_\_ Group: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscribers Employer: \_\_\_\_\_ Work# \_\_\_\_\_

### Secondary Insurance Information – Please give insurance card to receptionist to copy

Insurance Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscribers date of birth: \_\_\_\_\_

ID: \_\_\_\_\_ Group: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscribers Employer: \_\_\_\_\_ Work# \_\_\_\_\_

### Responsible Party Information

Name: \_\_\_\_\_ Home# \_\_\_\_\_ Wk# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(required unless paying Cash at time of service)

### Emergency Contact Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our office? \_\_\_\_\_

### Authorization/Acknowledgement

I hereby authorize treatment. I authorize Woodstock Family Medicine (WFM) to furnish to insurance carriers any medical information necessary to process my claims. I hereby assign WFM, all payments for medical services rendered to myself or my dependents. I understand that I am responsible for payment of any amount not covered by insurance. I acknowledge that insurance claims pending beyond 60 days are my responsibility. I understand that if my account is still outstanding after 90 days from the time that services were rendered, my account may be referred to a collection agency. I understand that it is my responsibility to obtain any referrals needed for treatment.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

**Woodstock Family Medicine  
5536 SE Woodstock Blvd  
Portland, Oregon 97206  
503 236-1830**

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## **HIPAA CONSENT FORM**

I give Woodstock Family Medicine my consent to use or disclose my health information to carry-out my treatment, to obtain payment from insurance companies and for health care operations like quality care reviews.

I have been informed that I may review Woodstock Family Medicine's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent if I so wish.

I understand Woodstock Family Medicine has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand Woodstock Family Medicine is not required to agree to the request. If Woodstock Family Medicine agrees to my requested restriction, they must follow the restriction, (except in the case of an emergency or required by law).

I also understand I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

\_\_\_\_\_  
Signature of patient or parent/legal guardian

\_\_\_\_\_  
Date

If signed by patient representative, relationship to patient: \_\_\_\_\_

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

(Health information may include but is not limited to: Appointment Reminders, Medication Education, Lab Results, Diagnostic Results, Treatment Plans or Options)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**As required by the Privacy Laws, Woodstock Family Medicine may not use or disclose your protected health information without your authorization: (See Below)**

I hereby authorize Woodstock Family Medicine and any of its employees to release to/or discuss information related to my health status with: (i.e. spouse, children, chiropractor, naturopath, psychologist....)

\_\_\_\_\_  
Name & Relationship to patient

\_\_\_\_\_  
Info okay to give

\_\_\_\_\_  
Name & Relationship to patient

\_\_\_\_\_  
Info okay to give

I decline

I wish to be contacted in the following manner for lab/test results, imaging reports, and any other questions/notifications Woodstock Family Medicine may have regarding my health care: **(Check all that apply)**

Home Telephone #: \_\_\_\_\_  
 Okay to leave message with detailed information  
 Leave message with call-back number only

Work Telephone #: \_\_\_\_\_  
 Okay to leave a message with detailed information  
 Leave message with call-back number only

Cellular Telephone #: \_\_\_\_\_  
 Okay to leave a message with detailed information  
 Leave a message with call-back number only

Written Communication: **(please circle)**  
- Okay to send to: Home Work/Office Fax #: \_\_\_\_\_

\_\_\_\_\_  
Signature of patient/legal representative

\_\_\_\_\_  
Date

# Woodstock Family Medicine

Dr. Melanie Smythe, DO ✓ Dr. Jerry Snow, DO

5536 SE Woodstock Blvd., Portland, OR 97206 Phone: 503-236-1830 Fax: 503-236-1908

## New Patient Child and Adolescent Intake Form

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

This child was born: Vaginally Cesarean (circle). Were there any complications during or immediately after the delivery? YES NO If yes, please describe: \_\_\_\_\_

### Past Healthcare Providers/Specialists:

NAME	LOCATION	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Past Medical History:

(circle or fill in those that apply)

- Neurological:** Seizures/Blackouts  
Headaches  
Vision Problems
- Ear/Nose/Throat:** Frequent Ear Infections  
Frequent Sinus Infections  
Seasonal Allergies
- Respiratory:** Asthma  
Cystic Fibrosis  
Pneumonia
- Cardiovascular:** Congenital Defects/Murmur  
High Blood Pressure  
Blood Clots
- Gastrointestinal:** Hernia  
Constipation
- Urinary/Reproductive:** Bladder/Kidney Infections  
Sexually Transmitted Diseases
- Skin:** Acne  
Eczema/Psoriasis
- Muscles/Bones:** Fractures/Sprains  
Scoliosis  
Growth Problems
- Endocrine:** Diabetes  
Thyroid Disorders
- Psychiatric:** Depression  
Anxiety  
ADD/ADHD
- Females Only:** Age at menstruation \_\_\_\_\_  
Painful or irregular periods
- Males Only:** Undescended Testicles  
Hypospadias

**Other:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Use this space for any explanation of circled/added items:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Surgical History:** (please list any operations and dates)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications:** (include herbs, over-the-counter & prescriptions):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies:** (include medicines and/or environmental allergies. Describe reaction):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History:** Please check condition and indicate family member who has the illness (sibling, parent, grandparent):

- |                                                    |                                         |
|----------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Birth Defect _____        | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Thyroid Disorder _____    | <input type="checkbox"/> Cancer _____   |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Asthma _____   |
| <input type="checkbox"/> Heart Disease _____       | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Seasonal Allergies _____  | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Mental Illness _____      | <input type="checkbox"/> Other _____    |
| <input type="checkbox"/> Kidney Disease _____      | <input type="checkbox"/> Other _____    |

Please turn over and complete the other side. Thanks!

**Infants:**

Is your baby breastfed or bottlefed with formula? (circle).

How many times per day does your baby nurse or take a bottle? \_\_\_\_\_

Do you have any concerns about how your baby is eating? YES NO

Do you have any concerns about your baby's sleep? YES NO

Do your baby seem to cry excessively? YES NO

**Young Children:**

Is your child in daycare? YES NO If not, who is the primary caregiver? \_\_\_\_\_

Do you have any concerns about your child's behavior? YES NO

Do you have any questions about potty training or has your child struggled with this? YES NO

Do you have any concerns about your child's sleep? YES NO

**School-Age Children:**

What school does your child attend? \_\_\_\_\_ What grade? \_\_\_\_\_

Do you have any concerns related to school? YES NO

Do you have any concerns about your child's behavior? YES NO

Do you have any concerns about your child's sleep? YES NO

**Adolescents:**

What school does your child attend? \_\_\_\_\_ What grade? \_\_\_\_\_

Do you have any concerns related to school? YES NO

Do you have any concerns about your child's behavior? YES NO

Is your child sexually active? YES NO If yes, do you have concerns about sexually transmitted diseases or preventing pregnancy? YES NO

Does your child smoke? YES NO If yes, how much in packs/day? \_\_\_\_\_

Does your child drink alcohol? YES NO If yes, how many drinks per/day or week? \_\_\_\_\_

Does your child use illicit drugs? YES NO If yes, what drugs and how often? \_\_\_\_\_

**Nutrition:**

Number of meals daily: \_\_\_\_\_ Servings of fruit/vegetables daily: \_\_\_\_\_

Usual snacks: \_\_\_\_\_

Special diet restrictions (other than allergies): \_\_\_\_\_

Number of caffeinated beverages daily: \_\_\_\_\_

Do you have any concerns about eating disorders? YES NO

**Health and Safety Questions?**

Are your child's immunizations up to date? YES NO *Please provide us with a copy of your child's immunization history.*

Is there fluoride in the water your child drinks? YES NO Does your child receive regular dental care? YES NO

Is your child exposed to second hand smoke often? YES NO

How many hours per day does your child spend watching TV, playing video games or using a computer? \_\_\_\_\_

How much time per day is your child playing outdoors or involved in sports? \_\_\_\_\_

Does your child wear their seat belt or use an approved car seat or booster seat whenever riding in the car? YES NO

Does your child wear a helmet when riding a bike or motorcycle? YES NO