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.

____ Medical records needed for continuity of care
____ Clinic office chart notes
____ Emergency and Urgent care records
____ Laboratory reports
____ Diagnostic imaging reports
____ Medication records
____ Billing statements
____ Gynecologic history, exams and Pap smears results
____ Contraception records
____ Physical therapy records
____ All Hospital records
____ Pathology reports
____ Most recent 5 years
____ 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, 42CRF 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

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: Health Questionnaire

NAME:____ **DOB:**___/___/______

REASON FOR VISIT:____

HOSPITAL ADMISSIONS: *Do not include normal pregnancies*

OPERATIONS	YEAR	ILLNESS	YEAR	ACCIDENT/INJURY	YEAR

MEDICATIONS: *INCLUDING VITAMINS, SUPPLEMENTS, AND OVER-THE-COUNTER MEDICATIONS*

DRUG ALLERGIES: *IF YOU HAVE NO DRUG ALLERGIES, PLEASE WRITE "NONE" BELOW*

FAMILY HISTORY: *if any blood relative has suffered any of the following, please circle the number & indicate which relative*

1) **Epilepsy (seizures)**
2) **Migraine Headaches**
3) **Mental Illness**
4) **Glaucoma**
5) **Diabetes**
6) **Thyroid disorder**
7) **Hay Fever**
8) **Asthma**
9) **Anemia**
10) **Blood clots**
11) **Osteoporosis**
12) **Arthritis**
13) **Heart Disease**
14) **Stroke**
15) **High BP**
16) **High Cholesterol**
17) **Alcoholism**
18) **Genetic Disease**
19) **Cancer (Type)**
20) **Intestinal Issues**
21) **Alzheimer's/Dementia**

Woodstock Family Medicine: Health Questionnaire

HABITS:

CIGARETTES/TOBACCO	ALCOHOL	CAFFEINE	REGULAR EXERCISE	DRUG/ALCOHOL TREATMENT
Packs or cans/day: # of yrs:	Drinks/wk:	Cups/day:	YES NO	YES NO
Quit: # of yrs:	Type:	Tea,Coffee,Soda?	Type & Frequency?	When? For?

MISC: *Please circle the following that pertains to you*

Tattoos/ Body Piercings/ Street Drugs/ Contact with Bodily Fluids/ Blood Transfusions/ High-Risk Sexual Behavior

MALES: Date of last prostate exam:______________

FEMALES: Menstrual Flow: Regular___ Irregular___ Painful___ Age of first menses:_________________

Date of last PAP:____________ First date of last menses:__________ Birth Control Method:_____________

# of Pregnancies______ # of Miscarriages______ # of Abortions_______ # of live births_________________

Infertility issues_____________________ Last Mammogram:______________ Last DexaScan:_____________

REVIEW OF SYSTEMS: ***please "X" to indicate you had & give age; please <u>circle</u> if it is a current issue***

Weight loss or gain	Heart Murmur	Sexually Transmitted Disease	Mental Illness
Unusual fatigue/energy loss	Irregular pulse/palpitations	Urethral discharge	Chicken Pox/Polio/Mumps
Severe headaches/Migraines	High cholesterol	Bruise easily/Anemia	Measles/German Measles
Dizzy/fainting spells	Swollen ankles	Cancer (type)	Tuberculosis/Herpes
Decreased Hearing/hearing loss	Calf pain w/ walking	Diabetes/excessive thirst	Rheumatic Fever/Scarlet Fever
Ringing in ears	Varicose veins/phlebitis	Thyroid Disease	Pain/Bleeding with sex
Frequent ear infections	Recent loss of appetite	Convulsions/Seizures	Failing vision/eye pain
Difficulty swallowing	Stroke	Indigestion/Heartburn	Double or Blurred vision
Tremors/Hands shaking	Glaucoma/Cataracts	Persistent nausea/Vomiting	Muscle Weakness
Frequent nose bleeds	Peptic ulcer/Abdominal pain	Numbness/Tingling Sensations	Sinus pain/Sore throats
Gallbladder problems	Arthritis/Rheumatism	Teeth/Gum pain-Bleeding	Jaundice/Hepatitis
Frequent back pain	Hoarseness/Chronic cough	Change in bowel habits	Bone fracture/Joint injury
Hay fever/Allergies	Diarrhea/Constipation	Gout/Osteoporosis	Pneumonia/Pleurisy
Bowl polyps Colitis/Crohn's	Foot Pain/Cold numb feet	Bronchitis/Emphysema	Stools: Bloody, Pale, Black
Rashes/Hives	Infertility History	Asthma/Wheezing	Hemorrhoids/Hernia
Eczema/Psoriasis	Shortness of Breath: with exertion/lying flat	Frequent Urinary infections/Urinary issues	Difficulty sleeping
Chest pain/Chest tightness	Memory loss	Phobias	High blood pressure
M o	- o	U	#)

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.

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