Maple Street Clinic, P.C.

FAMILY MEDICINE
1825 Maple Street
Forest Grove, OR 97116
Phone (503) 357-2136 Fax (503) 359-5479

The following forms are included in this packet. Please fill them out and sign and date them as indicated. This will speed up your check in process when you arrive at the clinic.

- **Patient Registration Form:** This form provides us with your contact and insurance information.
- **Financial Policy:** This policy outlines our financial practices.
- **Health History:** This information to help us understand your health conditions.
- **Authorization to Use/Disclose Health Information:** This form will allow us to get medical records from your previous healthcare provider.
- **Receipt of Notice of Privacy Practices:** This form acknowledges that you have received the Notice of Privacy Practices.
- **Notice of Privacy Practices:** This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

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PATIENT REGISTRATION FORM

Patient: **Address:** **Date of Birth**: **Social Security:** **Sex:** Male Female **Please mark best phone number to contact you:** **Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____ **Emerg Phone:** _____ **Emerg Contact Name:** _____ **Employer:** **Employer phone:** **Occupation:**	**Responsible Party** **Date of Birth:** **Social Security:** **List other minors in family:** **Name** **Date of Birth**

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other	**Race:** American Indian/Alaska Native Asian Black/African American Native Hawaiian Other Pacific Islander White Unreported

Marital Status: Married Single Divorced Widow **Provider:**
Spouse name: _____ **DOB** _____

Health Insurance Information: Please hand your insurance card and photo ID to the receptionist for scanning.

Primary Ins:	**Secondary Ins**:
Insured's SS #:	**Insured's SS#:**
Insured's Name:	**Insured's Name:**
Insured's DOB:	**Insured's DOB:**
Relationship to patient:	**Relationship to patient:**
Insured ID #:	**Insured Party ID #:**
Group #:	**Group #:**

Assignment of Benefits:
I hereby assign all medical and/or surgical benefits, including major medical benefits, to which I am entitled to Maple Street Clinic, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy or fax of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance except where my physician follows contractual obligations of an insurance plan as a participating provider. I understand and accept responsibility for all charges not able to be correctly billed to an insurance company because of invalid, incorrect, out of date, or insufficient information, or because of a lapse or change in insurance coverage not reported to the Maple Street Clinic. I authorize the release of all information necessary to secure payment. I agree to pay for all costs and expenses including reasonable attorney fees if it becomes necessary to effect collections on any amount owed.

Signed:_____ Date: _____
(Patient/Responsible Party, not a minor)

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FINANCIAL POLICY

Name of Patient: _____Date of Birth:_____

Guarantor: _____

Thank you for choosing the Maple Street Clinic. We are committed to providing you with quality medical care. Our fees reflect our professional commitment to excellence. This policy outlines our financial practices to avoid misunderstandings so we can pursue our primary goal of providing you excellent service.

We accept the following for payment: Cash, Check, Visa, MasterCard, Discover, Cashier's Check, Money Order

- Self-Pay patients are expected to deposit $150 at the first visit
- You will need to provide our office with your social security number and health insurance card (if applicable) unless your total charge is paid in cash at time of service. Treatment may be postponed if the above are not furnished by the patient.
- For services not covered by insurance, we offer a prompt pay discount. The estimated fee must be paid at the time of service with any balance due paid within 30 days. This discount will not be extended for medications, immunizations, or durable medical equipment.
- Patients with insurance are expected to pay co-pays at time of service. Many insurance plans have annual deductibles that aren't known until the insurance company is billed. Patients are billed and are responsible for those deductibles.
- As a courtesy, we will bill insurance. However, we are not able to negotiate disputed claims with insurance companies. If the insurance company fails to pay within 60 days, or if for any reason we are unable to bill the insurance company, patients are responsible for the balance of their accounts in full.
- There will be a $25 minimum, ($75 maximum) charge for no show appointments. The length of time scheduled determines the charge. If you can't make an appointment, our office needs to be notified as soon as possible to make that timeslot available for other patients. Although our clinic attempts to notify you one business day in advance of an appointment, we may not always be successful in reaching you. You assume responsibility for the appointment whether or not you receive a reminder call. We may not reschedule an appointment after 2 missed appointments have occurred.
- We assign delinquent accounts to a credit reporting collection agency. If it becomes necessary to effect collections on any amount of your account, you agree to pay a $75 collection fee plus all expenses, including reasonable attorney fees.

I have read the above financial policy and understand that regardless of any insurance coverage I have, I am responsible for payment on my account, and on the account of any persons I am financially responsible for. I hereby authorize the Maple Street Clinic to release all information necessary to secure payment.

_____ _____

Signature of Patient/Guarantor (not a minor) Date

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HEALTH HISTORY

To help us meet all your healthcare needs, please fill out the form as completely as possible in ink.
This is a confidential record of your medical history and will be kept in this office.

How did you hear about the Clinic &/or who referred you to the Clinic? _____
Place of Birth _____ Marital Status _____ Occupation _____
Hobbies/Exercise/Recreation_____
Date of last physical exam _____ Name of previous Doctor _____
Smoking/Tobacco _____ If former smoker, quit date _____
Alcohol _____ Caffeine _____
Other Drug Use _____ Usual Weight _____ Last dental exam _____
Please list all allergies _____
Date of your last tetanus shot _____ Date of last pneumonia shot _____

PAST MEDICAL HISTORY Please circle any condition you have ever had:

Measles, Migraine headaches, Hives or eczema, Mumps, Tuberculosis, Infectious mono, Chicken Pox, Diabetes, Bronchitis, Cancer, Mitral valve prolapse, Scarlet fever, Polio, Stroke, Glaucoma, Hepatitis, Smallpox, Hernia, Ulcer, Pneumonia, Kidney disease, Rheumatic fever, Thyroid disease, Heart disease, Back trouble, Bleeding tendency, Arthritis, Asthma, Anemia, Epilepsy, Bladder infections, Hemorrhoids, Venereal disease, High blood pressure, Blood transfusions, Whooping cough,

Please list any other disease or condition including serious accidents, injuries, fractures/broken bones, etc:

_____
_____
Please list all surgeries & other hospitalizations _____
_____

CURRENT MEDICATIONS Please list all medications you are currently taking:-

_____
_____
_____

FAMILY HISTORY Has any blood relative had any of the following? (leave blank if uncertain)

	Circle	Relationship		Circle	Relationship
Cancer	Yes No	_____	Lung Disease	Yes No	_____
Stroke	Yes No	_____	Leukemia	Yes No	_____
Tuberculosis	Yes No	_____	Drug/Alcohol Abuse	Yes No	_____
Epilepsy	Yes No	_____	Obesity	Yes No	_____
Diabetes	Yes No	_____	Thyroid Disease	Yes No	_____
Allergies	Yes No	_____	Glaucoma	Yes No	_____
Heart Disease	Yes No	_____	Gout	Yes No	_____
Anemia	Yes No	_____	Ulcer	Yes No	_____
High Blood Pressure	Yes No	_____	Depression	Yes No	_____
Bleeding Tendency	Yes No	_____	High Cholesterol	Yes No	_____
Asthma	Yes No	_____	Kidney Disease	Yes No	_____
Mental Illness	Yes No	_____			

	Present Age (age at death)	Health Conditions (If deceased, cause of death)
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Partner	_____	_____
Children	_____	_____

Patient Name_____ **Date of Birth**_____ **Date**_____

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Authorization to Use/Disclose Health Information

Patient Name	**Date of Birth**

Request records FROM::	**Send records TO:**
Name of Provider/Organization	Name of Provider/Organization **Maple Street Clinic PC**
Address	Address **1825 Maple St**
City, State, Zip	City, State, Zip **Forest Grove OR 97116**
Phone	Phone **503 357-2136**
Fax	Fax **503 359-5479**

Health care information to be used or disclosed consists of the last 2 years of medical records for continuity of care.
If specific records are needed for different purposes, please list.

Other _____ Time period _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **initials** in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Genetic testing information
_____ Mental health information
_____ Drug / alcohol diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

You are not required to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

To revoke this authorization, please send a written statement to Maple Street Clinic, P.C. and state that you are revoking this 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.

I have read and understand the above information and have asked questions for verification where needed.

Signature of Patient	Date	Parent/guardian of minor, or personal representative	Date

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Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____, have received a copy of the Notice of Privacy Practices.

Signature of Patient: _____ Date:_____

Signature of Guardian: _____ Date: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the

Clinic Administrator at 503-357-2136

1825 Maple Street, Forest Grove OR 97116

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Maple Street Clinic PC. Your health information may include information created and received by Maple Street Clinic PC, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for Maple Street Clinic PC in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your

family or friends unless you are unable to give permission to such disclosures due to your health condition.

For payment. We may use and disclose health information about you so that the treatment and services you receive at Maple Street Clinic PC may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run Maple Street Clinic PC and make sure that you and our other patients receive quality care.

  For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

  We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

  Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

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- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

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In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Clinic Administrator in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to the Clinic Administrator.
  Also, you have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the

information is kept by Maple Street Clinic PC.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Clinic Administrator.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be two pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request **in writing** to the Clinic Administrator. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

  We are required to agree to your request if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

  To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to the Clinic Administrator.

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- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Clinic Administrator. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice on our web site.

  To obtain such a copy, contact the Clinic Administrator

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location(s) with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region X – Seattle (Alaska, Idaho, Oregon, Washington)

U.S. Department of Health & Human Services

2201 Sixth Avenue - M/S: RX-11

Seattle, WA 98121-1831

Voice Phone (206)615-2290

FAX (206)615-2297

TDD (206)615-2296

To file a complaint with Maple Street Clinic PC, contact the Clinic Administrator at 503-357-2136. ***You will not be penalized for filing a complaint.***