

Bridge City Family Medical Clinic

Phone 503-460-0405

1410 NE 106th Ave, Portland, OR 97220

Fax 503-460-0434

Adult New Patient

Please Complete ALL Questions ~ We Require ALL Information to be Filled In

PATIENT INFORMATION					
Last Name	First Name	M.I.	Date of Birth	Check Which Applies	
			/ /	Male	Female
				FtoM	MtoF
				Other	
Address			City	State	Zip
Home Phone #	Cell Phone #	Work Phone #		Marital Status - check which applies	
()	()	()		Married	Single
				Divorced	Widowed
				Dom. Partner	
Employer	Employer Address		City	State	Zip
			Driver's License #		
Emergency Contact Name			Emergency Contact Phone #		

RESPONSIBLE PARTY = PARENT / GUARDIAN INFORMATION					
Last Name	First Name	M.I.	Date of Birth	Social Security #	
			/ /		
Address			City	State	Zip
Home Phone #		Cell Phone #			
()		()			

INSURANCE INFORMATION			
<u>Primary Insurance Company</u>	Insurance Address	State	Zip
Member ID #	Group #	Plan #	
Insurance Phone #	Insurance Coverage Type - check which applies		
		EPO	PPO
		POS	HMO
Subscriber / Patient Relationship - circle which applies			
Self	Spouse	Child	Other

<u>Secondary Insurance Company</u>	Insurance Address	State	Zip
Member ID #	Group #	Plan #	
Insurance Phone #	Insurance Coverage Type - check which applies		
		EPO	PPO
		POS	HMO
Subscriber / Patient Relationship - check which applies			
Self	Spouse	Child	Other

I hereby authorize *Bridge City Medical Clinic* to furnish information to insurance carriers concerning my illness and treatment and to imitate a complaint to the Oregon Insurance Commissioner on my behalf, if and when necessary. Assign any and all insurance benefits for treatment to *Bridge City Family Medical Clinic*. Acknowledge that I am ultimately responsible for any prior authorization or referral required by my insurance company. Assume complete financial responsibility for costs denied or rejected and for services not covered by my insurance company. Understand that any account sent to outside collections will be charged a \$40.00 Collection Fee which I am responsible to pay.

Patient/ Guardian Signature

Date

Bridge City Family Medical Clinic

Patient Responsibilities

Patient Responsibility: Patients are responsible for all charges resulting from treatment by *Bridge City Family Medical Clinic (BCFMC)*. As a service to you we will bill most insurance companies directly; however you are responsible for your account. Payment is due within thirty (30) days of receiving your bill, unless other payment arrangements are made. If your account goes to collection, you will be responsible for all fees incurred. *Patients are responsible for knowing what their insurance will and will not cover.*

Initial visit: At your first visit you will need to pay cash at the time of service. This will establish a credit history with the clinic. You must have your current insurance Card(s) and photo ID. Patients who do not need to pay cash at time of service are those with *HMO/ PPO* insurance, *Medicaid* and *Medicare* insurance, OHP members with the correct doctor (PCP), *Worker's Compensation* and established families with good credit history. You will be asked to pay for your visit if you do not have your current insurance information.

Insurance: You are responsible for deductibles, co pays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Copayments are due at the time of service. The remaining balance should be paid off within one (1) month of notice from the insurance company. If you or your insurance company makes a payment that exceeds your balance, reimbursement will be made. We will bill your primary insurance for you. *Providing correct insurance information is the responsibility of the patient/ guarantor.* Patients must bring their current insurance cards to each appointment. If payment cannot be made at each visit, notify the business office to make other arrangements.

HMO/PPO Plans: *Co-Payments are due at each visit.* You will not receive a monthly unless there is a balance owing from the patient.

Oregon Welfare and Oregon Health Plan: It is your responsibility to bring your current insurance card with you to each visit. If you do not bring your current card to your visit, you will be asked to reschedule your appointment.

Medicare: We are Medicare Providers.

Worker's Compensation: In order to file a Worker's Compensation claim, you will need the name of your insurance carrier, the date of your injury and your claim number. You must notify the scheduler that your appointment is for a worker's compensation injury.

Motor Vehicle or other Liability Claims: We will bill your auto insurance or other liability insurance on (1) time as a courtesy. Settlement of these claims can take several months, full payment for the visit or financial arrangements must be made at the time of service.

Divorced Parents: *BCFMC* will not be responsible for disputes between parents due to a divorce. The parent who brings the child in will be responsible for the bill unless a court order is brought to the appointment showing parent responsibility for bills.

Collection Charges: The Guarantor will be responsible for the cost of collection and/or court costs and reasonable legal fees. Accounts assigned to collections will be charged a fee of \$40.00.

Return Checks: Patients will be charged \$25.00 return check fee for checks that are returned by the bank; further payments must be made in case or money order.

Abusive Behavior: Verbal or physically abusive behavior towards staff will not be tolerated. This type of behavior will result in immediate discharge from the clinic.

Missed/ Late Appointments: You are expected to arrive 10 minutes prior to your scheduled appointment. If you arrive more than 10 minutes passed your scheduled appointment time we will need to reschedule your appointment. If we do need to reschedule your appointment due to being late or not showing up entirely, a \$25.00 charge may be billed to your account. Chronic tardiness and missed scheduled appointments may result in dismissal from the clinic.

Advanced Notice for Appointment Cancellations/ Reschedules: If a cancellation or reschedule is needed for a schedule appointment, *BCFMC* requires at least a one (1) day prior notice. Failure to cancel an appointment in the given time may result in a fee of \$25.00 billed to your account. Chronic failure to notify staff of cancellations or reschedules in the appropriate time may result in dismissal from the clinic.

Pharmacy: We require seventy-two (72) hours prior notifications on all prescription refills. Refill requests made on Friday will not be available until the following Monday. No refills will be done after hours or on weekends.

I have read and received a copy of the Patient Responsibilities for Bridge City Family Medical Clinic. I accept this policy for treatment with Bridge City Family Medical Clinic.

Print Patient / Guarantor Name

Signature Patient / Guarantor

Date

Bridge City Family Medical Clinic

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Fax 503-460-0434

Privacy Notice Acknowledgement

To our Patients:

Federal Law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have any questions about the Privacy Notice, please feel free to direct these to Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

I HAVE RECEIVED A COPY OF THE PRIVACY NOTICE

Print Patient Name

Signature of Patient/ Guardian

Date

Consent for Release of Protected Health Information

Patient Information

Name: _____ Date of Birth: _____
Street Address: _____ City _____ State _____ Zip _____
Also Known As: _____

I hereby authorize and give my permission to the providers/ individuals listed below to release and/or receive a copy of my record

To Bridge City Family Medical Clinic From Bridge City Family Medical Clinic To Verbally exchange with
FROM THE PARTY NAMED BELOW TO THE PARTY NAMED BELOW THE PARTY NAMED BELOW

Medical Facility/ Individual Records may be shared with

Name Individual records will be coming from or sent to (Provider, Doctor, Attorney) _____

Facility Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

Record Delivery Method

MAIL

FAX

Purpose for this Disclosure

Medical Care Legal Eligibility Determination Client Request Other

By **INITIALING BELOW, I GIVE MY PERMISSION TO RELEASE:** All records from all dates seen by Provider/ Clinic.

Physician Reports _____ Radiology Reports _____ Exam Forms _____
Medical Log _____ Immunization Records _____ Laboratory Reports _____ Other _____

Release of the following records & information requires specific authorization: By initialing the spaces below, I specifically authorize the voluntary release of the following medical records, if such records exist. I understand they are protected by Federal & State Law (ORS433.045(3); OAR33312270(8)(a); ORS659.7100). I also understand that I may revoke this authorization at any time to the extent that information has already been released based upon this authorization.
HIV/ AIDS _____ Sexually Transmitted Disease Info. _____ Mental Health Records _____
Genetic Information _____ Drug/ Alcohol Records _____

Patient Consent

My consent may be revoked at any time. The only exception is when the action has already occurred as instructed in the consent. In Oregon, unless revoked earlier, this consent will expire in 120 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request. I understand that by not signing this, I will still be able to receive medical care from Bridge City Family Medical Clinic.

Patient/ Guardian Signature: _____ Date: _____

The information disclosed to you by this authorization is protected by state law (ORS179.505.192.525) & Federal regulations (42 CFR Part 2, 45 CFD Parts 160-164). You are instructed that you may not further disclose this information without the written consent of the person to whom the information pertains. A general authorization for the release of medical information or other information is not sufficient for the purpose of alcohol/ drug treatment records. Federal rules restrict the use of alcohol/drug treatment records to criminally investigate or prosecute any alcohol/drug abuse patient.

These records are being requested for continuity of care. We are requesting this as a medical courtesy and do not offer reimbursement.

Bridge City Family Medical Clinic

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Patient Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Highest Level of Education: _____

Known Drug Allergies: _____

Current Medications/ Dose Info:

Medical History

(check which apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Abdominal Pain – Chronic | <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Anemia (bruise easily) | <input type="checkbox"/> Ankle – Swollen |
| <input type="checkbox"/> Appetite – Loss of | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Back Pain – Recurrent |
| <input type="checkbox"/> Bone Fracture/Joint Injury | <input type="checkbox"/> Bowel Habits – Change in | <input type="checkbox"/> Bronchitis/Chronic Cough | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Diverticulosis/Chrons/Colitis | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Ear – Ringing in | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Ear Infections – Frequent | <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Fatigue – Chronic | <input type="checkbox"/> Headaches – Frequent |
| <input type="checkbox"/> Foot Pain – Cold/Numbness | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Hernia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Indigestion/Heartburn | <input type="checkbox"/> Infections – Frequent | <input type="checkbox"/> Jaundice/Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Leg Pain – Walking | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Rashes/Hives |
| <input type="checkbox"/> Moodiness – Excessive | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Nausea/Vomiting – Persistent | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervous/Depression/Anxiety | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Numbness/Tingling Sensations | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Phobias | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Varicose |
| <input type="checkbox"/> Veins/Phlebitis | <input type="checkbox"/> Ulcers – Peptic | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Stools – Bloody/Tarry |
| <input type="checkbox"/> Psoriasis/Eczema | <input type="checkbox"/> Sexual Menstrual Dysfunction | <input type="checkbox"/> Weight Loss- Recent | <input type="checkbox"/> Swallowing Difficulty |
| <input type="checkbox"/> Throat – Sore/Frequent | <input type="checkbox"/> Tremora – Hands Shaking | <input type="checkbox"/> Urination Decrease in Force/Flow | |
| <input type="checkbox"/> Urination Painful/Loss of Control/Blood | | | |

Other _____

In general would you say your health is:

Date of Last Vaccine Tetanus _____ Flu _____ Pneumonia _____ Other _____

Hospitalization/ Surgery (Date/Reason):

Bridge City Family Medical Clinic

Are you seeing other healthcare providers?

If yes, who and why _____

Please describe any concerns that you have:

Family History

(Check which apply)

	<u>Your Mother</u>	<u>Your Father</u>	<u>Your Children</u>	<u>Your Siblings</u>	<u>Grandparents Mother's Side</u>	<u>Grandparents Father's Side</u>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Abuse/ Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis (A,B,C)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your Parents

Mother:
Living _____ Deceased _____

If Deceased, age and reason: _____

Father:
Living _____ Deceased _____

If Deceased, age and reason: _____

Bridge City Family Medical Clinic

Habits

Alcohol: Type _____ Amount _____

Coffee: Cups Daily _____

Soda/Juice: Daily Intake _____

Have you ever felt you ought to cut down on your drinking? Yes No

Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes No

Cigarettes: Do you smoke?

If yes, how many pack daily? _____ How long have you been smoking? _____

Interested in Stopping?

Diet: Recall, briefly what you have eaten in the last 24 hours. _____

Do you participate in regular exercise? Yes No

If Yes, What type? _____

Do you use any street drugs currently? Yes No

If Yes, What? _____

In the past? Yes No

If Yes, what & date last used? _____

Sleep: Difficulty Falling Asleep Early Morning Awakening

Difficulty Staying Asleep Daytime Drowsiness

During the past month, have you been bothered by feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by little interest or pleasure in doing things? Yes No

What is your relationship status?

Other: _____

What is your current living situation?

Do you feel safe in your relationship? Yes No

In the past year have you been threatened, hurt, afraid, slapped, kicked, or otherwise physically hurt by someone? Yes No

Do you consider yourself: Heterosexual (straight) Other: _____

May we record information about your sexual orientation and/or gender in your chart?

Are your current sexual partners:

In the past have your sexual partners been :

Have you been tested for HIV/ AIDS? Yes No Most recent HIV/AIDS test date? _____

Are you HIV +? Yes No

This section for female patients only

Are you Pregnant? Yes No

Bridge City Family Medical Clinic

Planning Pregnancy? Yes No
Have you experience hot flashes/menopause? Yes No
Number of Pregnancies: _____ Abortions: _____ Miscarriages: _____ Live Births _____

Are you interested in starting a new birth control method? Yes No

Birth Control Method N/A Pills Condoms Depo
IUD Diaphragm Sterilization Rhythm Method Pull Out
Other _____

Pain/Bleeding During/After Sex? Yes No
Date of Last Mammogram _____

First Day of Last Period? _____ Menstrual Flow

Days of Flow _____ Length of Cycle _____ Date of Last Pap Test _____ Normal Abnormal

This section for male patients only

Check if apply: Undescended testicle, testicular mass, lump Other _____

Patient Consent

I authorize release of any information necessary to process my medical insurance claim. I authorize benefits payable directly to Bridge City Family Medical Clinic, PC.

Patient / Guardian Signature Date

Provider Signature Date