Family Practice - Physicians & Surgeons

dunes family
health care

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Dear New Patient

Thank you for your interest in establishing care with Dunes Family Health Care, where our patients are our first priority. To determine placement for you, we would like you to read through the enclosed new patient information, complete all forms, and return them to us. It may take several days to review your application. If you have an immediate need to see a physician, please contact our office or write your need clearly and include it with your forms when you mail them back to us (or bring them in).

Once your information has been reviewed, you will be contacted and may be given an appointment date and time for your first visit. Your first visit with us will be a long visit to give our physician the opportunity to get to know you and your specific healthcare needs. For your first visit with us, we **ask you to arrive 30 minutes early** to allow time for your personal demographic and medical information to be entered into our computer system. ***Please bring with you all your medication bottles and/or vitamin supplements you take.*** This will allow our medical assistants to enter your medications accurately into our computer system.

We prefer to have all patients who are minors accompanied by a parent or guardian. If this is not possible, we **MUST** have the signature of the parent on the registration form as well as the signature and complete information for the responsible party.

We will attempt to verify your health insurance coverage prior to your first visit. Should we be unsuccessful in verifying your coverage, you will be expected to pay for your first visit at the time of service. Charges for subsequent visits will be filed with your insurance carrier. Our office uses a computerized billing and insurance claim system and we must have complete, accurate information if your claims are to be filed properly. We ask that you bring your insurance identification with you to **EACH** visit so that we may make a copy for our records.

From time to time emergencies or more lengthy procedures than anticipated may occur which cause our physicians to fall behind in their schedules. We realize that your time is important and will try to minimize this as much as possible. However, we do ask for your patience should this occur.

Because our physicians and nurse practioners' time is as valuable as yours, we ask that you contact our office promptly if you are unable to keep your appointment. A charge **of $25 will be imposed for missed appointments** and, should you continue to miss appointments, you may be placed on a *no scheduled appointment* basis.

Thank you again for your interest in Dunes Family Health Care. We look forward to getting to know you and your family and assisting you with your healthcare needs.

Sincerely

Sheri Aasen

Sheri Aasen
Clinic Manager

Dunes Family Health Care

620 Ranch Road, Reedsport, Oregon 97467 541-271-2163 fax 541-271-4058

PATIENT INFORMATION

Patient's Name ______________________________
Maiden/Other Name(s)______________________________
Social Security No ______________________________
Address ______________________________
City ________________ State _____ Zip ___________
Phone: Home ______________ Cell _____________
Date of Birth __________________ Sex ☐M ☐F
Employer ______________________________
Employer Address ______________________________
City ________________ State ____ Zip ___________
Veteran ☐Y ☐N Homeless ☐Y ☐N
Ethnic Group (voluntary) ______________________
Language ______________ Need Interpreter? ☐Y ☐N
Migrant Worker ☐Y ☐N Seasonal Worker ☐Y ☐N

RESPONSIBLE PARTY

Responsible Party's Name ________________________

Social Security No ______________________________
Mailing Address ______________________________
City ________________ State _____ Zip ___________
Phone: Home ______________ Cell _______________
Date of Birth __________________ Sex ☐M ☐F
Employer ______________________________
Employer Address ______________________________
City ________________ State ____ Zip ___________
Driver's License No _______________

Patient's Email: ____________________________

INSURANCE INFORMATION

Primary Insurance Name	Address (City, State, Zip)	Phone No
Name of Insured	Relationship	ID and Group No
Name of Insured	Relationship	ID and Group No

FAMILY INFORMATION

Spouse's Name ________________________________ Date of Birth _________________
Address ______________________________ City __________________ State ________ Zip __________
Phone: Home __________________ Work ____________________ Cell __________________
Employer ______________________________ Employer Address ______________________________
Nearest relative not living with you ______________________________ Relative's Phone _____________
Nearest friend not living with you ______________________________ Friend's Phone _____________
Children/Dependent(s):
Name ______________________________ Date of Birth ___________ Sex ☐M ☐F
Name ______________________________ Date of Birth ___________ Sex ☐M ☐F
Name ______________________________ Date of Birth ___________ Sex ☐M ☐F
Name ______________________________ Date of Birth ___________ Sex ☐M ☐F

Emergency Notification Name	Address	Phone	Business Phone	Relationship

I hereby authorize the above Health District to furnish the insured's insurance company all information which said insurance company may request concerning my present claim. I hereby assign to the Health District all money to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges not covered by this assignment.

______________________________ ______________________________ ____________
Responsible Party Signature Patient Signature Date

AUTHORIZATION: I __________________ (mother, father, legal guardian) hereby authorize Dunes Family Health Care / Lower Umpqua Hospital District to provide such medical services including surgery, if necessary, either regular or emergency, as may be determined to be in the best interest of those members of my immediate family, as listed above, who are minors. This authorization shall continue and be in full force and effect until revoked in writing.

Signature ______________________________ Date _______________
Parent or Guardian

dunes family health care 620 Ranch Rd, Reedsport, OR 97467 541-271-2163

Date ________________

NAME ________________________________ Date of Birth ______________ Sex: M F

Married ____ Separated ____ Divorced ____ Widowed ____ Single ____

Occupation ________________________ Education (high school / college) ______________

Do you have allergies? Yes ___ No ___ To What? ______________ Type of Reaction ______________

List all the medications you take, with dose (mg) and when you take it (include non-prescription type)

1. ____________ 4. ____________ 7. ____________
2. ____________ 5. ____________ 8. ____________
3. ____________ 6. ____________ 9. ____________

What concerns would you like to discuss with the provider?

1. ____________ 4. ____________
2. ____________ 5. ____________
3. ____________ 6. ____________

Surgeries	Month/Year	Doctor	Hospital	City/State
1.				
2.				
3.				
4.				

Hospitalization other than surgeries (excluding normal pregnancies)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Immunizations / Tests (place an X next to any you have had and give the year you last had them)

Year	Immunizations		Year	Immunizations	
____	__	Tetanus	____	__	Chest X-Ray
____	__	Flu	____	__	EKG
____	__	Rubella (German Measles)	____	__	TB Test
____	__	Mumps	____	__	Blood Count
____	__	Pneumonia Vaccine	____	__	Blood Chemistry Screen
____	__	Polio	____	__	Pap Smear
____	__	Other, What? ____________	____	__	Mammogram

List your health care goals

____________________ ____________________
____________________ ____________________
____________________ ____________________

How did you choose our clinic? ______________________________

Review of Systems (place an X next to each symptom you have experienced within the **last 2 weeks**):

____ Weight Change
____ Fatigue
____ Sweating/night sweats
____ Weakness

Skin
____ Hair/Nail Changes
____ Itching
____ Rashes

Head
____ Headache
____ Trauma
____ Dizziness
____ Fainting

Ears
____ Ringing
____ Difficulty Hearing
____ Frequent Infection

Last Eye Exam: ____________
____ Vision/Glasses
____ Blurring
____ Floaters
____ Double Vision
____ Pain
____ Discharge
____ Cataract
____ Glaucoma

Nose
____ Sinusitis
____ Bleeding
____ Discharge
____ Obstruction
____ Postnasal Drip

Mouth/Throat
Last Dental Exam: ____________
____ Sores
____ Gum Bleeding
____ Teeth
____ Hoarseness
____ Dentures
____ Taste

Pulmonary
____ Wheezing
____ Difficulty Breathing
____ Coughing Blood
____ Cough
____ Sputum
____ Smoking, How many/day ______

Breasts
____ Masses
____ Pain
____ Discharge

Cardiovascular
____ Palpitations
____ Chest Pain/Pressure
____ Murmurs
____ Edema/Ankle Swelling
____ Difficult Breathing Lying Down
____ Varicose Veins
____ Blue Skin/Nails
____ Leg Pain While Walking
____ Rheumatic or Scarlet Fever

Gastrointestinal
____ Appetite Change
____ Indigestion
____ Hernia
____ Blood in Stool or Black Stool
____ Constipation
____ Anal Discomfort
____ Hemorrhoids
____ Nausea, Vomiting, Diarrhea
____ Hepatitis
____ Food Intolerance or Avoidance
____ Ulcer
____ Painful Swallowing
____ Abdominal Pain
____ Liver Problems
____ Change in Bowel Habits
____ Gall Bladder Problem

Genitourinary
____ Painful Urination
____ Prostate Problem
____ Testicular Pain/Swelling
____ Frequency
____ Urgency/Incontinence

Sexual History
____ Sores/Discharge
____ Infertility
____ Painful Intercourse
____ Contraception:
____
____ Pregnancies:
____
____
____

Female
____ Menopause/Symptoms
____ Cramps
____ Irregular Menses

Menses:
Duration ______________
Cycle Length ______________
Last Pap Smear ______________
Results ______________
____

Endocrine
____ Goiter/Thyroid
____ High Blood Sugar
____ Hormone Therapy
____ Heat/Cold Intolerance

Allergies
____ Sensitivity to allergens/ drugs vaccines
____ Asthma
____ Eczema
____ Hay Fever
____ Hives

Bones, Joints, and Muscle
____ Trauma
____ Swelling
____ Pain/Arthritis

Blood-Lymphatic
____ Anemia
____ Bleeding Tendency
____ Blood Disease
____ Transfusions
____ Lymph Node Enlargement/Pain

Neurologic
____ Fainting
____ Convulsions
____ Numbness/Tingling
____ Gait/Coordination Problem
____ Speech Problems
____ Paralysis/Weakness

Psychologic
____ Memory Loss
____ Mood Problems
____ Irregular Sleep
____ Anxiety
____ Depression
____ Phobia
____ Drug/Alcohol Abuse
____ Recreational Drug Use
If yes, what and how often?
____

Have you or any relative ever had the following?

No	Yes		Who (father, mother, etc.)
____	____	Diabetes	____________
____	____	Glaucoma	____________
____	____	Thyroid Problem	____________
____	____	High Blood Pressure	____________
____	____	Heart Trouble	____________
____	____	Stroke	____________
____	____	Cancer or Tumor	____________
____	____	Tuberculosis	____________
____	____	Emphysema	____________
____	____	Anemia	____________
____	____	Bleeding Disorder	____________
____	____	Ulcer	____________
____	____	Arthritis	____________
____	____	Gout	____________
____	____	Allergy / Asthma	____________
____	____	Suicide	____________
____	____	Mental Illness	____________
____	____	Nervous Breakdown	____________
____	____	Kidney or Bladder Trouble	____________
____	____	Epilepsy or Convulsions	____________
____	____	Birth Defects	____________
____	____	Drug Use	____________
____	____	Other, What? ____________	

Dunes Family Health Care
620 Ranch Road, Reedsport
Ph: 541-271-2163
Fx: 541-271-4058

Patient Name: ______________________________ **Date of Birth:** ____________________

Thank you for choosing the care of our physicians and nurse practitioners. Please take a moment to review our financial policy.

FINANCIAL POLICY

- Payment for services and insurance co-payments are expected at the time of service. Temporary billing arrangements for services are available to approved applicants only. Patients without any insurance should be prepared to make payment the same day of their appointment. Any exceptions must be approved by the Business Office ***prior to the appointment***, with the first payment due the day of the visit. If circumstances make this policy a hardship, we will attempt to tailor payment terms to your specific needs.

- **Please be prepared to show your insurance information at each visit**. We will bill your insurance carrier (primary & secondary) if you provide us this information. Our clinic participates with many insurance plans. Please check with your specific plan regarding participation status.

- Cash payments at the time of service will result in a 20% discount of charges for those services. We accept cash, check, debit or credit cards.

- Accounts which require payment arrangements on a balance owed require monthly payments of no less than $50.00 per month or 1/12th the balance due – whichever is greater. Accounts are due, and payable in full, one year from the date of service. Patients requiring an extended payment plan will be considered with a request to the Dunes Family Health Care Clinic Manager for review.

- Payment is due within 10 days of receipt of the monthly statement ***Please call or write us immediately if your circumstances have changed, or if you believe there is an error on your account.*** We will promptly respond to any inquiry.

- This clinic offers the payment plan option as a courtesy for accounts kept current. Delinquent accounts may be referred to a collection agency. **If the account is sent to a collection agency, you may be dismissed from this practice and we will no longer provide your medical care.**

- Patients who do not notify the clinic twenty-four (24) hours prior to their scheduled appointment, or as soon as possible in unavoidable situations, or arrive later than fifteen (15) minutes after their appointment time, will be charged a $25 fee.

- By signing below I agree that I have reviewed and understand the information above.

______________________________ ______________________
Signature Date

For estimated charges, or to arrange a payment plan, contact the Dunes Family Health Care billing department at 541-271-2163.

ACKNOWLEDGEMENT AND CONSENT

PATIENT NAME ______________________________ DATE OF BIRTH ________________

PATIENT PRIVACY

I understand that DUNES FAMILY HEALTH CARE (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some of all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a *Notice of Privacy Practices* and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time, and that I am entitled to receive a copy of any revised *Notice of Practice*. I also understand that a copy or a summary of the most current version of This Practice's *Notice of Privacy Practices* in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the *Notice of Privacy Practices*, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the *Dunes Family Health Care Patient Rights*. I have also reviewed the *Notice of Privacy Practices* and may receive a copy if I so request.

PATIENT REFERRAL CHOICE

I understand that I have the right to receive my diagnostic test or health care treatment or service at a facility of my choosing. If I choose to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner at Dunes Family Health Care, I am responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by me.

By signing below, I agree that I have reviewed and understand the information above and that I have received and reviewed a copy of the *Dunes Family Health Care Patient Referral Notice*.

By: ______________________________ Date: ________________
Patient Signature Printed Name:

-OR-

By: ______________________________ Date: ________________
Patient Representative
Description of Representative's Authority: ______________________________

Dunes Family Health Care / Lower Umpqua Hospital District
Family Practice Physicians and Surgeons
620 Ranch Road
Reedsport, OR 97467

Phone 541-271-2163
Fax 541-271-4058

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name ______________________________ Date of Birth________________

This gives our office permission to speak to anyone that might call other than your physician. Please list by name and relationship.

PLEASE PRINT

1. ________________________________ Relationship ________________
   Name

2. ________________________________ Relationship ________________
   Name

3. ________________________________ Relationship ________________
   Name

4. ________________________________ Relationship ________________
   Name

Please initial below information you authorize to be released that is pertinent to your medical history.

_______ Scheduling / appointment information

_______ Billing and payment information

_______ Lab, x-ray, operative and procedure reports, hospitalization reports

_______ Alcohol/drug treatment

_______ Behavioral Health / Psychiatric information

_______ HIV/AIDS information

_______ Sexually transmitted diseases

_______ Hepatitis treatment

I acknowledge with the signing of this form the medical data to be released may include information that is specific to HIV/AIDS drug and/or alcohol and/or psychiatric treatment (if initialed), which cannot be released without a separate consent. This consent is subject to revocation at any time by me.

Patient Signature: ______________________________ **Date**______________

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize (the doctor/facility where you have been seen most recently):

x	Name of Person or Facility:		
	Address, City, State, Zip:		
	Phone:	Fax:	Email:

To use or disclose to:

Name of Person or Facility:	DUNES FAMILY HEALTH CARE
Address, City, State, Zip:	620 RANCH ROAD, REEDSPORT, OR 97467
Phone: 541-271-2163	Fax: 541-271-4058

The MEDICAL RECORD (protected Health Information) OF:

Patient Name:		Date of Birth:
Address, City, State, Zip:		
Phone:	Medical Record No:	SSN (last four):
Treatment Dates From:	To:	

Put a CHECKMARK next to the specific documents that apply to your request:

	Progress Notes		History & Physical Exam		Other, Please describe:
	Laboratory Reports		EKG Reports		
	X-Ray Reports		Spirometry Report		
	Discharge Summary		Physician Orders		

Place your INITIALS in the applicable boxes below to authorize the release of SENSITIVE information pertaining to:

	Mental Health		Drugs & Alcohol		HIV/AIDS/ Other Infection Disease		Genetic Testing		None of these apply

Put a CHECKMARK next to the purpose of the request:

	Continued Patient Care		Social Security / Disability		Insurance		Other:
	Personal		Attorney / Legal		Worker's Comp		

I UNDERSTAND THAT:

- I may revoke this authorization at any time:
  - The revocation will not apply to information that has already been released in response to this Authorization
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to Dunes Family Health Care Manager.
- I may refuse to sign this Authorization:
  - My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
  - A fee may be charged for copying the protected health information. Please contact office to obtain fee and rate information @ 541-271-2163.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in ninety (90) days from the date of signature.

I have read and understand the information in this Authorization form.

Signature of Patient:	
Printed Name:	Date:
Signature of Authorized Representative:	
Printed Name:	Date:
Please explain Representative's authority to act on the behalf of the Patient:	
OFFICE USE ONLY	
Processed Date: ____________________ Processed By: ________________________________	Stamps / Additional Notes:

Forms/Auth to Release Infor – New Patient
July 2014

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGMENT

THIS NOTICE DESCRIBES YOUR REFERRAL RIGHTS WHEN YOUR HEALTH CARE PROVIDER REFERS YOU TO ANOTHER PROVIDER OR FACILITY FOR ADDITIONAL TESTING OR HEALTH CARE SERVICES.

In accordance with Oregon law, when you are referred for care outside of our clinic, we, Dunes Family Health Care, are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patient's clinical needs and personal health choices.
- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
  - (a) That when referred, a patient has a choice about where to receive services; and
  - (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner;
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the patient.
- A health practitioner shall not deny, limit or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.

By signing below, I acknowledge that I have read and understand my referral rights as outlined above.

Patient Signature ______________________ Date __________

Print Patient Name ______________________

-OR-

Parent, Guardian, Responsible Party, Legal Representative Signature ______________________ Date __________

Description of Representative's Authority ______________________

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