REEDSPORT MEDICAL CLINIC
Lower Umpqua Hospital District

385 Ranch Road
Reedsport OR 97467

WELCOME

Enclosed you will find the paper work necessary to obtain an appointment with our Doctors. Please complete these forms and return them to our Receptionist. Upon approval, we will call you for an appointment. Normal response time is within a week of receipt of your application.
We appreciate your selection of this clinic to serve your medical and health needs, and will do all we can to provide the best of care. We have prepared this letter to answer some of the most common questions about our policies and the medical care we provide. If you need further assistance please contact our office staff.

TELEPHONES

Our main telephone number is 541-271-2119, our main fax number is 541-271-9338
For billing questions please call 541-271-2171

OFFICE HOURS

The office is open 8:00am to 5:00pm Monday through Friday. We are closed on all major holidays.

AFTER HOURS

If a medical emergency occurs, please call 911.
If a non-emergent question or medical concern occurs after regular office hours, please call and leave a message, you will be contacted the next business day.

CONTACTING YOUR PHYSICIAN

When you call our office please be prepared to tell our receptionist if your call is regarding an appointment, a medical question, or a prescription refill. For medical concerns, the Medical Assistant will contact you at their earliest opportunity.

CO-PAYS and SELF PAY

Your co-pay is due at the time of your office visit. This amount is determined by your insurance company. Patients who are self-pay will be required to bring a $50.00 deposit at the time of visit. We do have financial assistance plans that you may talk with the billing department about if needed.

PRESCRIPTIONS AND REFILLS

To request prescription refills, please **first contact your pharmacy before your medications run out**. Your pharmacy will notify us for necessary authorization. Prescriptions that require written refills will be handled by the Medical Assistant. You will need to allow 2 business days for a response. All controlled substance prescriptions will now require a face-to-face visit with the physician prior to the prescription pick-up every 30 days. This appointment must be scheduled. This is now a clinic policy and is in accordance with regulatory demands. Please insure that you bring all your medications, including all over-the-counter medication to each physician appointment.

CANCELLATIONS AND NO-SHOWS

Patients who have missed 2 appointments (whether due to cancellation or no –shows) will be notified by formal letter that they will no longer be entitled to schedule an appointment for the future. The patient who has missed 2 appointments will now have the option of calling in every day to see if there is an appointment that is available that day. These patients will no longer be given the opportunity to schedule their own future appointments. Same day appointments will be given on a first come, first serve basis only.

UPDATING RECORDS

Updating your information is important. We require an up-date of your records on a yearly basis. We will need all of the information about your insurance coverage at the time of your visit. If there are any changes such as telephone, address, or insurance before your update please notify us as soon as possible.

THE GOAL OF REEDSPORT MEDICAL CLINIC

Our goal at Reedsport Medical Clinic is to give you the best quality of care in the most efficient way. We know that your time is valuable. We ask you to check in for your appointment 15 minutes prior to your appointment. This allows for updating paperwork or information in the Electronic Medical Record. It also allows for time for the medical assistant to "room" you in preparation for your practitioner to see you. If you are late for an appointment, you may be re-scheduled.

We strive to provide the best possible care. We make prevention and wellness a top priority. If you have a special health concern or condition, your health care team will help you connect with other professionals to get you the care you need. We are your health care team. Your team is led by your primary care provider and they will communicate with the other health care team members to provide for your optimal care.

Sincerely, Reedsport Medical Clinic

LOWER UMPQUA
HOSPITAL DISTRICT
600 Ranch Road
Reedsport, OR 97467
(541) 271-2171

Reedsport Medical Clinic

Lower Umpqua Hospital Walk-in Clinic

Dear Patient,

We are pleased to inform you of a new service being provided to you. The Patient Portal will provide you with online access to your health information, such as lab results, a copy of your current medical summary, and the ability to email your medical provider. If you wish to sign up, please fill out the information below and we will be happy to get you set up.

E-Mail:_____@_____

Or

Cell Phone Number:_____ & Phone Carrier_____

Patient Signature:_____ Date:_____

Opt-Out:

If you feel that using the Patient Portal to access your health information is not your preferred method of communication, you may choose to "opt out". If you choose to opt out, please indicate your choice below for our records. If you decide at a later time to opt back into the Patient Portal, please contact our office for assistance.

By signing below, you are stating you would like to opt-out of the Patient Portal at this time.

Patient Signature:_____ Date:_____

Internal Information

Patient Sticker	☐ Information was entered into Patient Registration ☐ Generated portal pin in Medical Summary ☐ Patient Portal Registration was completed in Practice Portal and patient was sent a message

Reedsport Medical Clinic
No Show Policy

Policy

Patients who fail to contact the office to cancel or reschedule their appointment prior to the date of their appointment are to be considered a no-show. All no-shows will be documented in the chart, made known to the provider and will be assessed a $25 fee.

Should the patient contact the office with what is considered a legitimate reason for their missed appointment, their explanation will be documented in the chart along with the noted "no-show".

Any attempt made by staff to contact the patient to reschedule an appointment will be documented in the patient's chart.

If a patient has three (3) documented no-shows in their chart within one year, a letter will be mailed to the patient indicating that appointments will no longer be made in advance for them. The letter will inform them that they should either seek services elsewhere or they will be restricted to available service as of the day they call, no appointments will be made in advance for them. A notation of this will be placed in their MPI and a copy of the letter will be scanned into the patient's chart.

Patients new to the clinic who miss their first appointment will be noted in the MPI and will be assessed a $25 fee. Should the patient miss their second scheduled New Patient Visit, they will not be accepted into the practice.

My signature below is an indication that I have read and understand this Policy.

Sign _____ Date _____

REEDSPORT MEDICAL CLINIC

Lower Umpqua Hospital District

TODAY'S DATE: **PRIMARY PHYSICIAN:**

PATIENT INFORMATION

Patient's Last name: First: Middle I.: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Email Address:

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Social Security no.: Home phone no.: ( )

P.O. box: City: State: Zip: Cell / alternate phone no.: ( )

Occupation: Employer: Work no.: ( )

Spouse's Name: Phone #: Spouse DOB: Spouse SSN:

Clinic chosen because / Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Are you a Veteran? ❑ Do you receive monthly Veteran's benefits? ❑ Do you receive Medical care from the VA? Where? Driver License Number:

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

IF TREATMENT IS FOR A WORK OR ACCIDENT RELATED INJURY, NOTE INSURER, CLAIM # AND DATE OF INJURY BELOW:

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: Employer: Employer address: Employer phone no.: ( )

Primary Insurance: Subscriber's Name: I.D.#: Group #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other Co-Pay:

Name of secondary insurance (if applicable): Subscriber's name: I.D.#: Group #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

I certify that I have insurance coverage with _____

and assign directly to **Lower Umpqua Hospital District** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named facility may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I request that payment of authorized Medicare and or Medigap benefits, if applicable, be made on my behalf to **Lower Umpqua Hospital District** for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Patient or Guardian Date

Please print name of Patient or Guardian Relationship to Patient

Date of last physical exam: _____ **Reason for this visit:** _____

Please check symptoms you currently have or have had:

General
O Chills
O Depression/Nervousness
O Dizziness/ Fainting
O Fever
O Forgetfulness
O Headache
O Loss of sleep
O Loss of weight
O Numbness
O Sweats
O Fatigue

Muscle/Join/Bone
O Pain, weakness, numbness in:
O Arms O Hips
O Back O Legs
O Feet O Neck
O Hands O Shoulders

Genitourinary
O Blood in urine
O Frequent urination
O Lack of bladder control
O Painful urination
O Kidney disease
O Sexually transmitted disease

Pulmonary
O Pneumonia
O Tuberculosis
O Persistent cough
O Wheezing
O Shortness of breath
O Wake with shortness of breath
O Asthma

Gastrointestinal
O Poor Appetite
O Bloating
O Bowel changes
O Constipation
O Diarrhea
O Excessive thirst
O Gas
O Hemorrhoids
O Indigestion
O Nausea
O Rectal Bleeding
O Stomach pain
O Vomiting
O Vomiting blood
O Liver disease
O Hepatitis
O Ulcers
O Difficulty swallowing
O Heartburn

Cardiovascular
O Chest pain
O Chest pressure
O High blood pressure
O Low blood pressure
O Irregular/ rapid heartbeat
O Poor circulation
O Swelling in ankles
O Varicose veins
O Heart disease
O High cholesterol
O Pacemaker
O Stroke

Eyes, Ears, Nose, Throat
O Bleeding gums
O Blurred vision
O Crossed eyes
O Double Vision
O Earache/ Ear discharge
O Hay fever
O Hoarseness
O Loss of hearing
O Nosebleeds
O Ringing in the ears
O Sinus problems
O Vision-flashes/halos
O Migraines
O Snoring
O Thyroid problems
O Glaucoma
O Cataracts

Skin
O Bruise easily
O Hives
O Itching/rash
O Change in mole
O Scars
O Sore that won't heal

Disease and Conditions
O HIV positive
O AIDS
O Multiple Sclerosis
O Mumps
O Bleeding disorders
O Measles
O Cancer: _____
O Polio
O Rheumatic fever
O Scarlet fever
O Diabetes
O Chicken Pox
O Epilepsy
O Herpes

Men Only
O Erectile Difficulties
O Lump in testicles
O Penis discharge
O Sore on penis
O Prostate problem
O Breast lump
O Other

Women Only
O Abnormal PAP
O Bleeding between periods
O Brest Lump
O Extreme menstrual pain
O Hot flashes
O Nipple discharge
O Painful intercourse
O Vaginal discharge
O Other

Date of last menstrual period: _____

Date of last PAP: _____

Date of last Mammo: _____

Are you pregnant? _____

Describe serious illness or operations _____

Family Health History

	Age	Age of Death	Significant health problems cause of Death		Age	Age of Death	Significant health problems cause of Death
Father				**Children** O M O F			
Mother				O M O F			
Siblings O M O F				O M O F			
O M O F				**Grandmother** Maternal			
O M O F				**Grandfather** Maternal			
O M O F				**Grandmother** Paternal			
O M O F				**Grandfather** Paternal			

Medications/ Allergies and Sensitivities

List your prescribed and over-the-counter medications or attach a sheet:
_____
_____

List allergies and sensitivities to medications:
_____

Health habits

Check any you use and how much:
O Caffeine _____
O Tobacco _____
O Alcohol _____
O Street drugs _____
O Other _____

Check if your work exposes you to:
O Stress
O Heavy Lifting
O Hazardous Substances
O Second-hand smoke
O Other _____

Health Information Questionnaire

SPECIALISTS: Please list any specialists you are currently seeing or have seen in the past:

Specialty	Provider	Address	Phone	Last Seen
Example: Cardiology	*Dr. Heart*	*123 North Street, Reedsport OR 97467*	*(800) 123-4567*	*1/2000*

HOSPITALIZATIONS and SURGERIES:

List any hospitalizations, surgeries or procedures you have had performed.

What & Where	Date	What & Where	Date
Example: Colonoscopy at Lower Umpqua Hospital	*1/2010*		

HEALTH MAINTENANCE:

If you've had a test or vaccine done, list when last performed:

❑ Bone density test: _____

❑ Cholesterol screen: _____

❑ Colonoscopy: _____

❑ Dental Exam: _____

Wear dentures? Y/N Upper/Lower?

❑ Diabetes screen: _____

❑ Eye exam: _____

Wear glasses? Y/N Contacts? Y/N

❑ Flu vaccine:

_____

❑ Hearing test: _____

Wear hearing aids? Y/N Left/Right

❑ Hep A vaccine: _____

❑ Hep B vaccine: _____

❑ Hep C Testing: _____

❑ HIV testing: _____

❑ HPV vaccine: _____

❑ Meningococcal vaccine: _____

❑ Pneumonia vaccine: _____

❑ Prostate exam (males): _____

❑ Shingles vaccine: _____

❑ Tetanus vaccine: _____

ADVANCED DIRECTIVES:

Do you have an Advance Directive such as a Living Will or POLST form? ❑ Yes ❑ No. If yes, please provide a copy.

Would you like information on the preparation of these? ❑ Yes ❑ No

LOWER UMPQUA
HOSPITAL DISTRICT

Health Information Questionnaire

WORK / SCHOOL:

Education: through grade: ____ ❑ high school ❑ tech ❑Associates ❑ Bachelor's ❑ Master's ❑ PhD

Do you work: ❑ Full-time ❑ Part-time ❑ Retired ❑ Unemployed ❑ Disabled. If disabled, how? _____

Current or prior occupation: _____.

Military Service? ❑ Yes ❑ No Any financial concerns? ❑ Yes ❑ No

SOCIAL HISTORY:

Place of birth: _____ Any recent travel? ❑ Yes ❑ No. If yes, where? _____

Any travel outside the US? ❑ Yes ❑ No. If yes, where and when? _____

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ In a relationship

Religion: _____ Any religious restrictions/concerns? ❑ Yes ❑ No. If yes, explain: _____

HOME / ENVIRONMENT:

Living arrangement: ❑ House ❑ Apartment ❑ Condo ❑ Dorm ❑ Homeless ❑ RV/Motorhome ❑ Other: _____

Lives with: ❑ Self ❑ Spouse ❑ Significant Other ❑ Children ❑ Parents ❑Siblings ❑ Roommates ❑ Other: _____

Number of persons in household: ____. Smokers in household? ❑ Yes ❑ No

Alcohol abuse in household? ❑ Yes ❑ No. Substance abuse in household? ❑ Yes ❑ No

Pets/Animal in home: _____Hobbies/Sports: _____

SAFETY:

Smoke detectors in the home? ❑ Yes ❑. Guns in the home? ❑ Yes ❑ No

Do you wear a seat belt? ❑ Yes ❑ No. Do you wear a helmet? (for biking, skiing, skateboarding, etc.) ❑ Yes ❑ No

In the past year, have you ever been: Afraid of your partner? ❑ Yes ❑ No. Physically hurt by your partner? ❑ Yes ❑ No.

Raped or forced to have sexual activity by your partner? ❑ Yes ❑ No

Emotionally abused by your partner? ❑ Yes ❑ No.

Do you have stairs in the home? ❑ Yes ❑ No. Have you fallen in the past year? ❑ Yes ❑ No.

Do you use a walking aid? ❑ Yes ❑ No. If yes, ❑ Cane ❑ Walker ❑ Wheelchair ❑ Scooter

LOWER UMPQUA
HOSPITAL DISTRICT

Health Information Questionnaire

NUTRITION / HEALTH:

Do you eat a healthy diet? ❑ Yes ❑ No. How many servings of fruit daily? ____. Vegetables daily? ____

Diet: ❑ Regular ❑ Calorie restricted ❑ Vegetarian ❑ Kosher ❑ Diabetic ❑ Renal ❑ Other: _____

Salt Intake: ❑ Low ❑ Medium ❑ High. Fat intake: ❑ Low ❑ Medium ❑ High. Water intake: _____

Do you regularly exercise? ❑ Yes ❑ No. How many times per week? _____. How long? _____

What type of exercise (e.g. biking, walking, running, swimming, etc.)? _____.

GENITOURINARY:

Are you sexually active? ❑ Yes ❑ No

First active at age: _____ Current # of partners: _____ Number of life partners: _____

Length of time with current partner(s): _____ Any concerns about STDs or HIV? ❑ Yes ❑ No.

Birth control method/STD prevention: ❑ None ❑ Condoms ❑ Pill ❑ IUD ❑ Other: _____

Self-described orientation: ❑ Straight ❑ Lesbian ❑ Gay ❑ Bi-Sexual ❑ Transgender ❑ Transsexual ❑ Other: _____

OB/GYN HISTORY (females only):

Age at onset of menstruation: _____ Date of last menstruation: _____ or Age at menopause: _____

Period every _____ days. Duration of period: _____ days. Light / Moderate / Heavy Periods? (circle one)

How many pregnancies: _____ How many children: _____Vaginal or C-section _____

Date of deliveries: _____

Signature _____ Date: _____

Reviewed _____ Date: _____

LOWER UMPQUA
HOSPITAL DISTRICT

Lower Umpqua Hospital District
600 Ranch Road

Reedsport Medical Clinic
385 Ranch Road, Reedsport

Ph: (541) 271-2119
Fax: (541) 271-9338

****

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

FINANCIAL POLICY

- Payment in full at time of visit is expected. Temporary billing arrangements are available to *approved* applicants only, and 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.

- We will bill your insurance carrier (primary & secondary) if you provide us this information. Our physicians participate with many insurance plans. Please check with your specific plan regarding participation status.

- Cash payments at the time of a service will result in a 20% discount of charges for those services. (Cash, check, debit or credit card)

- 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 Specialty Clinic Office Manager for review.

- Payment is due within 10 days of receipt of the monthly statement.

- The Specialty Clinic offers the payment plan option as a courtesy for accounts kept current: Delinquent accounts will be referred to a collection agency. *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.

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

- _____ _____

  Signature Date

****

For estimated physician charges, or to arrange a payment plan, contact the Lower Umpqua Hospital Clinic Billing Department at (541) 271-2171.

REEDSPORT MEDICAL CLINIC
Lower Umpqua Hospital District
385 Ranch Road
Reedsport OR 97467

Representative Authorization

□ My information is not to be released to anyone.

□ I authorize Reedsport Medical Clinic / Lower Umpqua Hospital District to share my personal information regarding my health care needs with:

1. _____

2. _____

3. _____

4. _____

Their Address is:

1. _____

2. _____

3. _____

4. _____

Their Telephone number is:

1. _____

2. _____

3. _____

4. _____

This Release of Information will remain in effect until terminated by me in writing.

Patient Signature: _____ Date:_____

Witness: _____ Date: _____

Right to revoke: Client's signature below revokes this release of Information.

_____ Date: _____
(Signature revoking Release of Information)

INSTRUCTIONS FOR COMPLETING A RELEASE OF INFORMATION FORM

If you are filling out the release of information form online, or are mailing the form to us, please read over the instructions. We follow the HIPAA guidelines when handling requests so each section is important to complete.

- In the box at the top of the page is the section for us to enter your MR# and I.D. information. We are required to check I.D. of the person requesting the records. If you are sending the release to our facility please attach a copy of your driver's license or other I.D. with photo and signature. If this is not done we cannot make and send the copies requested. This must be the I.D. of the patient, or the legally authorized party.

- The first section is self-explanatory for name of facility releasing information, patient name, date of birth, and who will receive the records. If possible, please include the address and phone number.

- The second section is to mark the purpose of the records request.

- The third section of the form asks that you **initial** by the copies you are requesting. A check mark in these areas is **not** the same thing. ***Please initial***. The items in the box marked "Sensitive Records" must be initialed for that information to be released.

- The fourth section is so that a date or event that you enter can be the time frame in which the request is active, and then will expire. If not marked then this authorization is good for a period of 6 months from the date of the signature.

- The fifth and final section **requires** the signature of the individual whose records are being requested. If that person is not available or unable to sign, the person picking up the records must have a "Power of Attorney for Healthcare" and bring their I.D.
  If that individual wanting records is a minor, then a parent or guardian needs to sign the bottom of the form where noted.
  If the person is deceased and a party requests records, they must be a close relative such as parent/spouse and be able to prove they have executorship over the deceased's belongings, bring a death certificate and proof of their identity.

REEDSPORT MEDICAL CLINIC
Lower Umpqua Hospital District
395 Ranch Road
Reedsport OR 97467

MRN:_____ *ID CHECKED:*_____ *BY:*_____

AUTHORIZATION TO DISCLOSE or OBTAIN MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize *(facility)* _____ to release a copy of the medical information

for *(name of patient)* _____

(date of birth) _____ to *(name and address of recipient)*_____

_____

The information will be used on my behalf for the following purpose:
[_] Continuity of Care, [ ] Personal Records, [ ] Insurance, [ ] Other _____

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

PLEASE INITIAL		PLEASE INITIAL
___ All hospital/clinic records (including nursing notes/progress notes)	____Progress Notes/Medication	SENSITIVE RECORDS
____Most recent 2 year history (dictations, labs, x-rays)	____ Records for continuity of care (dictations, labs, x-rays)	____ Mental Health Records
____Physical Therapy records	____ Emergency care records	____ Drug/Alcohol records
____Laboratory reports	____ Billing statements	____ HIV/AIDS related records
____Operative reports and/or Path reports	____ Radiology reports	____Genetic Testing information

____Other: _____

I ask that this authorization expire on (date) _____ or on (an event. If no date or event is specified, this authorization will be in effect for a period of six (6) months from the date signed below. Upon conclusion of that time period (*unless earlier revoked by me in writing*), this authorization is automatically revoked. I understand that I may revoke this authorization at any time by notifying Lower Umpqua Hospital in writing except to the extent that action has been taken in reliance on this authorization.

This authorization is limited to:
Following date's/treatment: _____

Workers compensation claim for injuries of _____ (*date*) _____

_____ _____
(date) *(Signature of patient) or (guardian/person authorized by law)*

_____ _____
(date) *Witness – staff at facility*

Revised on: 05/2018

REEDSPORT MEDICAL CLINIC
Lower Umpqua Hospital District
385 Ranch Road
Reedsport OR 97467

MRN:_____ *ID CHECKED:*_____ *BY:*_____

AUTHORIZATION TO DISCLOSE or OBTAIN MEDICAL RECORDS

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize *(facility)* _____ to release a copy of the medical information

for *(name of patient)* _____

(date of birth) _____ to *(name and address of recipient)* _____

_____

The information will be used on my behalf for the following purpose:
[_] Continuity of Care, [ ] Personal Records, [ ] Insurance, [ ] Other _____

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

PLEASE INITIAL

___ All hospital/clinic records
(including nursing notes/progress notes)

____Most recent 2 year history
(dictations, labs, x-rays)

____Physical Therapy records

____Laboratory reports

____Operative reports and/or Path reports

____Progress Notes/Medication

____ Records for continuity of care
(dictations, labs, x-rays)

____ Emergency care records

____ Billing statements

____ Radiology reports

PLEASE INITIAL

SENSITIVE RECORDS

____ Mental Health Records

____ Drug/Alcohol records

____ HIV/AIDS related records

____Genetic Testing information

____Other: _____

I ask that this authorization expire on (date) _____ or on (an event. If no date or event is specified, this authorization will be in effect for a period of six (6) months from the date signed below. Upon conclusion of that time period (*unless earlier revoked by me in writing*), this authorization is automatically revoked. I understand that I may revoke this authorization at any time by notifying Lower Umpqua Hospital in writing except to the extent that action has been taken in reliance on this authorization.

This authorization is limited to:
Following date's/treatment: _____

Workers compensation claim for injuries of _____ (*date*) _____

_____ _____
(date) *(Signature of patient) or (guardian/person authorized by law)*

_____ _____
(date) *Witness – staff at facility*

Revised on: 05/2018

ACKNOWLEDGMENT AND CONSENT

I understand that REEDSPORT MEDICAL CLINIC (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 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 or all of my health care;
- 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 Privacy Practices. I also understand that a copy or summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting 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 <u>have received</u> a copy of the Notice of PATIENT PRIVACY. We have available the NOTICE OF PRIVACY PRACTICES which we will provide upon your written request.

By: _____ **Date:** _____
(Patient)

-OR-

By: _____ **Date:** _____
(Patient Representative)

Description of Representative's Authority: _____

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 Office Manager at (541) 271-2119
Reedsport Medical Clinic, 385 Ranch Road, Reedsport, OR 97467

WHO WILL FOLLOW THIS NOTICE

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

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, 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. If 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 about you 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, office 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 office may share information about you and disclose information to people who do not work in our office 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.

- **For Payment.** We may use and disclose health information about you so that the treatment and services you receive at this office 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 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 the office 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 of 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 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 or safety and safety of the public or another person.

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

- **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 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 release 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 about you 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 release health information about you in a way that does not personally identify you or reveal who you are.

- **Family and Friends.** We may release 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 is 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 during treatment or while treatment is discussed.

  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 y our 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 precious 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.

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 Office Manager 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 may deny your request to inspect and/or copy records 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 that the 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 this office. To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Office Manager.

- 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 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.

- **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, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

  To obtain this list, you must submit your request **in writing** to the Office Manager. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. 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.

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

- **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 email.

  To request confidential communications, you may complete and submit a REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to the Office Manager. 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. To obtain a copy, please contact the Office Manager.

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 in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe that 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. To file a complaint with our office, please contact the Office Manager at (541) 271-2119. ***You will not be penalized for filing a complaint.***