DUNES FAMILY HEALTH CARE
Lower Umpqua Hospital District
620 Ranch Road
Reedsport OR 97467
Phone: (541) 271-2163
Fax: (541) 271-4058

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 providers' 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, Dunes Family Health Care

Dunes Family Health Care

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

DUNES FAMILY HEALTH CARE
Lower Umpqua Hospital District

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
Lower Umpqua Hospital District

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 (how often)

DUNES FAMILY HEALTH CARE
Lower Umpqua Hospital District

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
Lower Umpqua Hospital District

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 $1/12^{th}$ 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.

Policy/FinancialPolicy

Dunes Family Health Care
Lower Umpqua Hospital District
Family Practice Physicians
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

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

_____ Scheduling / appointment information
Initial

_____ Billing and payment information
Initial

_____ Lab, x-ray, operative and procedure reports, hospitalization reports
Initial

_____ Alcohol/drug treatment
Initial

_____ Behavioral Health / Psychiatric information
Initial

_____ HIV/AIDS information
Initial

_____ Sexually transmitted diseases
Initial

_____ Hepatitis treatment
Initial

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**_____

Witness Signature:_____ **Date**_____

DUNES FAMILY HEALTH CARE
Lower Umpqua Hospital District

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: _____

LOWER UMPQUA HOSPITAL DISTRICT ~ 600 Ranch Road, Reedsport, OR 97467
P: (541) 271-2171 ~ F: (541) 271-6322 (Medical Records) or (541) 271- 6363 (Emergency Room) as requested.
DUNES FAMILY HEALTH CARE ~620 Ranch Road, Reedsport, OR 97467
P: 541-271-2163 F: 541-271-4058
REEDSPORT MEDICAL CLINIC ~385 Ranch Road, Reedsport, OR 97467
P: 541-271-2119 F: 541-271-9338

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 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. I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive healthcare services or reimbursement for services except in the circumstance that 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. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of Lower Umpqua Hospital District or myself. However, I also understand that federal and state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions or genetic information.

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)***

_____ _____ revised on: 06/2020

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

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, 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.

DUNES FAMILY HEALTH CARE
Lower Umpqua Hospital District

NOTICE OF REFERRAL RIGHTS AND ACKNOWLEDGEMENT

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 Helah 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.
- If a health practitioner refers a patient for a diagnostic test or health care treatment or service at a facility in which the health practitioner or an immediate family member of the health practitioner has a financial interest, the health practitioner or the practitioner's designee shall inform the patient orally and in writing of that interest at the time of the referral.
- If a health practitioner refers a patient to a facility for a diagnostic test or health care treatment or service, the health practitioner or the practitioner's designee shall inform the patient, in the form and manner prescribed by the Oregon Health Authority by rule, that:
    - The patient may receive the test, treatment or service at a different facility of the patient's choice, and
    - If the patient chooses a different facility, the patient should contact the patient's insurer regarding the extent of coverage or the limitations on coverage for the test, treatment or service at the facility chosen by the patient.
- A health practitioner may not deny, limit or withdraw a referral to a facility solely for the reason that the patient chooses to obtain the test, treatment or service from a different facility.

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	

April 2019