Family Practice - Physicians & Surgeons

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dunes family
health care

620 ranch rd -reedsport, oregon 97467 - ph 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 physicians and nurse practitioners' 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
Clinic Manager

Confidential Health Questionnaire:

Date of last physical examination ________________ What is your reason for this visit? ________________

Please check symptoms you currently have or have had in the past below

GENERAL
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats
- ☐ Fatigue

MUSCLE/JOINT/BONE
- ☐ Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Kidney Disease
- ☐ Sexually Transmitted Disease

☐ **PULMONARY**
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Short of breath
- ☐ Wake with shortness of breath
- ☐ Asthma

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Difficulty swallowing
- ☐ Taste acid in throat

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Chest pressure
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Stroke

EYES, EARS, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes/Halos
- ☐ Migraine Headaches
- ☐ Snoring
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Cataracts

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

DISEASES AND CONDITIONS
- ☐ HIV Positive
- ☐ AIDS
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Bleeding Disorders
- ☐ Cancer: ________________
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Herpes

MEN ONLY
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Prostate Problem
- ☐ Breast Lump
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period________________

Date of last Pap Smear________________

Date of last mammogram________________

Are you pregnant?________________

Describe serious illnesses 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**	☐ M ☐ F			
Mother						☐ M ☐ F			
Sibling(s)	☐ M ☐ F				**Grandmother** Maternal				
	☐ M ☐ F				**Grandfather** Maternal				
	☐ M ☐ F				**Grandmother** Paternal				
	☐ M ☐ F				**Grandfather** Paternal				

MEDICATIONS/ALLERGIES AND SENSITIVITIES

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

____

____

____

List allergies and sensitivities to medications:

____

____

I certify that this information is correct to the best of my knowledge. I will not hold the clinic staff responsible for any errors I may have made in the completion of this form.

HEALTH HABITS

Check which you use and how often:
- ☐ Caffeine________________
- ☐ Tobacco________________
- ☐ Alcohol________________
- ☐ Street Drugs________________
- ☐ Other________________

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

Signature________________________________**Date:**____________

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 ______________

INSURANCE INFORMATION

Primary Insurance Name	Address (City, State, Zip)	Phone No
Secondary Insurance Name	Address (City, State, Zip)	Phone 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 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
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

5. ________________________________ Relationship ________________
Name

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

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

_______ Alcohol/drug treatment

_______ Psychiatric information

_______ HIV/AIDS information

_______ Sexually transmitted diseases

_______ Hepatitis

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: ______________________	Stamps / Additional Notes:
Processed By: ____	

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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