ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
Rogue River, Oregon 97537
www.rogueriverfpc.com
541-582-0505

WELCOME

Thank you for choosing Rogue River Family Practice Clinic to serve your medical needs. Please complete the enclosed registration packet as soon as possible so that we can get your record established in our system. Please be sure to fill out **both sides** of the paperwork.

Please be sure to fill out the "Records Release Authorization" with the **name and address** of your former physician. Be sure to ***initial*** the spaces required.

Please be sure to include a copy of your insurance card(s) both front and back sides and mail it back to the office with your packet.

Please return paperwork to our office:

Rogue River Family Practice Clinic
(Mailing) P.O. Box 1020
(Physical) 509 E. Main St.
Rogue River, OR 97537

* There is no need to send back the informational pages, just the pages you fill out.

** Please note additional postage may be required to send your forms through the postal service.

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PATIENT INFORMATION

Last name _____ First _____ Middle _____ Gender ☐ F ☐ M

SS# _____ Date of birth _____ Cell phone _____

Primary language _____ Driver's license # _____ Home phone _____

E-mail address _____ Work phone _____

May we leave information on your cell phone/answering machine to confirm your appointment? ☐ Yes ☐ No

Mailing address (☐ check if same as street address) _____

City _____ State _____ Zip _____

Street address _____

City _____ State _____ Zip _____

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's name _____ Date of birth _____ Spouse's phone _____

OHRP INFORMATION *(required by the State)*

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline

Race ☐ Asian ☐ Black/African American ☐ American Indian
☐ Alaskan Native ☐ Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Declined

EMPLOYMENT

☐ Full-time ☐ Part-time ☐ Not employed ☐ Full-time student ☐ Part-time student ☐ Retired

Employer _____ Phone _____

Employer address _____

EMERGENCY CONTACT

Name _____ Relationship _____

Address _____ Phone _____

If patient is a child, parent's name _____ Phone _____

INSURANCE

Primary insurance _____ Secondary insurance _____

Subscriber name _____ Subscriber name _____

Date of birth _____ SS# _____ Date of birth _____ SS# _____

ID# _____ Group# _____ ID# _____ Group# _____

Subscriber's relationship to patient _____ Subscriber's relationship to patient _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Rogue River Family Practice Clinic to provide my insurance companies with all information necessary to process insurance claims and assign payments to Rogue River Family Practice Clinic all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as valid as the original.

I have read and understood all of the above.

Signature _____ Date _____

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HEALTH HISTORY

Name _____ Date _____

Date of birth _____ Referred by _____

Are you under the care of any other physician/provider? ☐ Yes ☐ No

Please list other health care providers _____

_____

SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ No Average amount (daily, weekly, or monthly) _____

Do you drink alcohol? ☐ Yes ☐ No Average amount (daily, weekly, or monthly) _____

WOMEN ONLY

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____ # of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

MEN ONLY

Date of last prostate exam _____ Date of last PSA test _____

Date of last colonoscopy _____ Date of last Dexa Scan _____

PAST MEDICAL HISTORY *(check all that apply)*

☐ Coronary artery disease
☐ Heart rhythm
☐ Heart infections/Inflammation
☐ Heart malformations
☐ High blood pressure
☐ Heart muscle disorders
☐ Other _____
☐ Diabetes Type I
☐ Diabetes Type II
☐ Hypothyroidism
☐ Psychiatric condition
☐ Cancer (type and location) _____

DIABETIC PATIENTS

Date of last foot exam _____ Date of last eye exam _____

Date of last A1c _____ Date of last cholesterol panel _____

Name _____ Date of Birth _____ Today's Date _____

PREVIOUS SURGERIES

	Type	Year	Surgeon	City
1				
2				
3				
4				
5				
6				
7				

FAMILY HISTORY

IF LIVING

Father Age _____ Health _____

Mother Age _____ Health _____

IF DECEASED

Father Age at Death _____ Cause _____

Mother Age at Death _____ Cause _____

# of Children _____ # living _____ # deceased _____ Ages of each _____

Serious illnesses of children _____

_____

FAMILY MEDICAL HISTORY *(Please check and note relationship. If grandparent, please specify maternal or paternal.)*

- ☐ Coronary artery disease
- ☐ Heart rhythm
- ☐ Heart infections/Inflammation
- ☐ Heart malformations
- ☐ High blood pressure
- ☐ Heart muscle disorders
- ☐ Other _____
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypothyroidism
- ☐ Psychiatric condition
- ☐ Cancer (type and location) _____

Disclaimer: This document will be scanned. The scanned copy will be as good as the original.

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MEDICATIONS

Preferred pharmacy _____

ALLERGIES AND REACTIONS *(please include medications, foods, latex, dye, etc.)*

CURRENT MEDICATIONS *(list all medications, including prescription, vitamins, over-the-counter, and herbs)*

Medication	Dose	Frequency	Reason for taking

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CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO FRIENDS OR FAMILY MEMBERS

Patient Name_____ Date of Birth_____

CONSENT

I request Rogue River Family Practice Clinic to release protected healthcare information to:

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

Name_____

Relationship to Patient_____

This request and authorization applies to: (please check below)

☐ All healthcare information (Medical and Billing)

☐ Healthcare information relating to the following treatment, condition or dates:

_____

_____

☐ Other_____

I understand that this designation applies only to Rogue River Family Practice Clinic.

Patient Signature_____ Date Signed_____

REVOCATION/TERMINATION

I request to revoke/terminate the designation made above.

Patient Signature_____ Date Signed_____

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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 designated Privacy Officer of our office at 541-582-0505; 509 E. Main St., Rogue River, OR 97537

EFFECTIVE JUNE 2, 2017

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. It 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 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 heath 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.

- **Health Information Exchange** A health information exchange (HIE) is a system that electronically moves and exchanges patients' Protected Health Information (PHI) between participating health care providers who have been approved to sue the system and who have a unique log-in and password. Rogue River Family Practice Clinic participates in the Reliance eHealth Collaborative.

  Reliance facilitates the sharing of PHI among authorized health care providers (e.g., health systems, hospitals, physician offices and labs) and health information organizations for treatment, payment and operation (TPO) purposes. Reliance is a secure system designed according to nationally recognized

standards and in accordance with federal and state laws that protect the privacy and security of the information being exchanged. Your PHI is available to authorized health care providers and , where appropriate, authorized care coordinators, through Reliance, unless you decline to participate or "opt-out" by completing a Reliance Request for Opt-Out Form.

Reliance will not sell or disclose your PHI to any third party for any commercial or activity unrelated to TPO, as defined by federal laws (HIPAA and HITECH), including, but not limited to, marketing or fundraising activities.

- **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 here 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 or 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 providers that 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 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.

- **Marketing Health-Related Services** We will not use your health information for marketing communications without written, prior authorization. We will not sell your PHI to another organization for marketing or any other purpose.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all the 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 and safety or the health and safety of the public or another person.

- **Required By Law** We will disclose 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 health 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 disclose 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 or problems with products.
- **Health Oversight Activities** We may disclose health information to a health oversight agency for audits, investigations, inspections, accreditation 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 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 use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends** We may disclose health information about you to your family members or friends if we obtain your written authorization 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 if we can infer from the circumstances, based on our professional judgment, that you would not abject. 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 your behalf to pick up, for example, filled prescriptions, medical supplies or X-rays.
- **Deceased Person's PHI** We may disclose a deceased person's PHI to family or others involved in the person's care or payment for care, unless our practice knows the deceased preferred that certain people not receive the PHI. Disclosures are limited to the PHI directly relevant to the person's involvement.

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 previous 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.

You have the right to be notified following a breach of your PHI by our practice.

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 our designated Privacy Officer, 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 your health information, 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 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 designated Privacy Officer.

  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 designated Privacy Officer. 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 or electronically). The first list you request within a 12-month period will be free. For additional lists, we will charge you for providing the list. We will notify you of the cot involved and you may choose to withdraw or modify your request at that time before any charges 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 operation. 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 form to the designated Privacy Officer.

- **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 mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to our designated Privacy Officer. 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 Request an Opt-Out in Health Information Exchange** Patients who do not want their health information to be accessible to authorized health care providers through the Reliance eHealth Collaborative may choose not to participate or "opt-out". If you choose to opt-out and complete a Reliance Opt-Out Form, health care providers will not be able to search for your records through Reliance, except in the case of a medical emergency.

  Please note that your health care provider must agree to make your information available for treatment if you choose to participate. This means that your health care provider may not accept a request not to disclose your PHI to other authorized health care providers and care coordinators participating in the HIE.

  If you previously submitted an Opt-Out form and would now like to begin participating again or "opt-in", you may complete a Reliance cancellation of Opt-Out Form. This includes any health information (e.g., test results) that was generated while you were opted-out. By submitting a Cancellation Form, your health information will again be accessible to authorized health care providers through Reliance. Your request may not be processed immediately so when you opt-in, your information may not immediately be available to your provider(s).

  Please contact Reliance at support@RelianceHIE.org or (855)290-5443 for more information on how to opt-out, or to cancel a previous opt-out request.

- **Right to a Paper Copy of This Notice** If you have received this notice electronically, 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 such a copy, ask the receptionist.

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 a summary of the current notice in the office with its effective date. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe 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, contact the designated Privacy Officer at 509 E. Main St., Rogue River, OR 97537. **You will not be penalized for filing a complaint.**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (print patient name), acknowledge and agree that I have received a copy of Rogue River Family Practice Clinic's Notice of Privacy Practices.

Patient signature _____ Date _____

Patient legal representative signature _____ Date _____

Print name of legal representative _____

Relationship to patient _____

FOR CLINIC USE ONLY

Rogue River Family Practice Clinic made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

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FINANCIAL POLICIES

Thank you for choosing Rogue River Family Practice Clinic as your medical provider. We have written this policy to keep you informed of our current financial policies.

NO INSURANCE

Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements. Account balances over $250.00 will be required to pay in full at the time of their appointment.

INSURANCE

Although we are contracted with several insurance companies, it is your responsibility to make sure that our provider is in your plan. It is also your responsibility to know your insurance benefits and inform us of any changes in your insurance coverage. This ensures accurate billing and referrals. As a courtesy, we will bill up to two of your insurances. We cannot become involved in disputes with your carrier regarding your benefits.

Co-pays are due at the time of service. It is your responsibility to know the amount of your co-payment. The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

For your convenience we accept cash, checks, debit cards, Visa, MasterCard, and money orders. Payments are also accepted over the phone.

AUTO ACCIDENT

We will bill for motor vehicle accidents, but only as a courtesy. If your motor vehicle insurance carrier does not pay or does not pay in a timely manner, then payment in full is your responsibility. We will supply any information that may be needed for you to submit to your motor vehicle insurance.

LIABILITY INJURY

If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We will not file your insurance, but will provide you with a receipt to do so.

WORKER'S COMPENSATION

If your injury is due to an accident in your work place, please inform the receptionist before you see the provider. It is your responsibility to know your employers workers compensation insurance information (name and billing address).

MEDICAL RECORDS

We will provide you a copy of your medical records upon request, one time for no charge. Any further copies will require a fee. You will need to sign a letter of release prior to having them copied. Please allow up to 30 days for this request to be processed.

RETURNED CHECKS

There is a $25.00 return check fee on all returned checks.

BILLING

If you receive a bill from us, it is because we believe the balance is your responsibility. Please contact your insurance company first if you think there is a problem. If you have any questions about your bill, please call our billing department immediately. If you cannot pay your entire balance, please call to make payment arrangements: 541-582-0505, option 3.

COLLECTIONS

Accounts that are not paid within 30 days will begin our in house collection process. If your balance is not paid monthly and in a timely manner, you may be subject to dismissal from the practice.

ACKNOWLEDGMENT

I acknowledge that I have received and read a copy of the Rogue River Family Practice Clinic financial policies.

Signature/ Patient or Guardian _____ Date _____

A copy of this form will be provided at your request. Please inform the receptionist.

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NO SHOW POLICY

In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of all our patients.

If it is necessary to cancel your scheduled appointment we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

HOW TO CANCEL YOUR APPOINTMENT

To cancel appointments you may call 541-582-0505.

LATE CANCELLATIONS

Late cancellations will be considered as a "no show."

NO SHOW POLICY

A "no show" is someone who misses an appointment without canceling it 24 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in our appointment scheduler as a "no show." The first time there is a "no show," the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. If you have three "no shows," in one year, we will no longer see you at our practice.