Sunrise Family Clinic

Registration Form

Patient's Full Name: _____ **Previous Name(s):** _____

Address: _____

Phone: Home _____ **Cell** _____ **Work** _____ **Other** _____

E-Mail Address: _____ **Date of Birth:** _____

Social Security Number: _____-____ -_____ **Employer Name:** _____

Please circle:

Sex: M - F **Ethnicity:** Hispanic or Latino - Not Hispanic or Latino - Declined

Race: American Indian - Alaska Native - Asian - African American - White - Other _____ - Declined

Preferred Language: English - Spanish - Other _____

Marital Status: Married - Single - Divorced - Widowed - Legally Separated - Partner

Employment Status: Full-Time - Part-Time - Not Employed - Self-Employed - Retired - Active Military

Student Status: Full-Time Student - Part-Time Student - Not a Student

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

□ Check here and skip to next section if information is same as patient

Responsible Party Full Name: _____ **Date of Birth:** _____

Social Security Number: _____-____ -_____ **Employer Name:** _____

Address: _____

Phone: Home _____ **Cell** _____ **Work** _____ **Other** _____

E-Mail Address: _____ **Date of Birth:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ **Relationship:** _____

Phone: Home _____ **Cell** _____ **Work** _____ **Other** _____

Do you have a living will, advanced directive, or healthcare power of attorney? Yes - No

If yes, please provide us with a copy to keep in your file.

Sunrise Family Clinic

Registration Form, p2

Name: _____

INSURANCE INFORMATION: **You must present your insurance card(s) to the front desk at check-in.**

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. I understand that I, the undersigned patient and/or guarantor am responsible for charges incurred. It is a courtesy for Sunrise Family Clinic (SFC) to file my insurance, and I am responsible for my copay and/or percentage, and in the event my insurance company does not pay, I am responsible for the balance due. It is also my responsibility to be aware of or call my insurance regarding their requirements for prior authorizations or referrals. If these are not obtained before the visit, I am liable for any charges. If SFC is unable to obtain payment within a reasonable amount of time from the patient and/or guarantor, SFC reserves the right to place your account with a collection agency, which will leave me liable for additional expenses incurred if applicable. I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to Sunrise Family Clinic. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits.

_____ _____

Patient or Responsible Party Signature Date

Sunrise Family Clinic

Consent to Treatment

Name: _____

I, the undersigned, recognize the following information related to my treatment at Sunrise Family Clinic (SFC).

A. As a patient, I have the responsibility to:

- Actively work with my provider to solve problems and to develop goals.
- To discuss my treatment plan, ask questions when I don't understand, and make changes when needed.
- Take medications as prescribed by my provider, or discuss why I think I will not be able to take the medication.
- Notify my provider of any changes in my medications or if additional medications have been prescribed for me.
- Seek additional help for any mental health, alcohol or drug problems.
- Treat Sunrise Family Clinic staff and other patients with respect.

B. I understand and agree that SFC may use and disclose my heath information in the manner described in SFC's Notice Privacy Practices. In signing this form, I acknowledge that I have received the opportunity to read and review SFC's Notify of Privacy Practices and had any questions regarding it answered.

C. I authorize SFC or SFC's designee to disclose to payors including, but not limited to, insurers, the Centers for Medicare and Medicaid Services, or any other parties that may be liable for all or part of the SFC charges ("Third Party Payors"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to SFC. I also authorize SFC to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my provider or SFC, as may be necessary. I understand that SFC will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or clinic operations.

D. Releases:

Can SFC staff to LEAVE DETAILED MESSAGES (such as lab results) ON YOUR ANSWERING MACHINE OR VOICEMAIL? □ **Yes** □ **No** **Initials:** _____

Can SFC staff to discuss your care with anyone other than yourself? □ **Yes** □ **No**

Please list names: _____ _____

_____ _____ **Initials:** _____

Can SFC access your pharmacy records to allow us to better care for you and prevent medication interactions?

□ **Yes** □ **No:** if no, please explain _____ **Initials:** _____

Would you like SFC to have our automated system text or call to remind you about appointments and labs results?

□ **Yes** □ **No:** if no, please explain _____ **Initials:** _____

I understand that I have the right to refuse to sign this consent. If I refuse to sign this consent or if I revoke this consent in the future I understand that SFC will not provide any treatment to me or arrange for treatment on my behalf, except under certain emergencies or if otherwise required by law.

I understand that this consent will remain in effect until I provide notice that I would like this consent to be discontinued or revoked.

I hereby give my voluntary informed consent to treatment, including diagnostic procedures, surgical and medical treatment as discussed with my provider, at Sunrise Family Clinic. I also understand that I will be billed for services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments or examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care. If I should leave SFC against medical advice or prior treatment being completed, I hereby relieve provider and SFC of all liability for my action. Please contact us if you have any questions.

_____ _____

CLIENT SIGNATURE DATE

Sunrise Family Clinic

1. Patient Name: _____ Maiden/former Name: _____
   Address: _____
   Birth Date: _____ Contact Phone: _____

2. I authorize the following organization(s):
   _____
   _____
   _____
   _____

   To Release to:
   Sunrise Family Clinic
   351 SE Baker Street
   McMinnville, OR 97128
   Fax: 503-474-3601 Phone: 503-474-3600

3. Information to be released:
☐ All medical history, including chart notes, laboratory and imaging results, consultation reports, etc.
☐ Admission histories and physicals, discharge summaries, and all laboratory and imaging results
☐ Other (specify)_____
_____
_____

I specifically authorize the release of the indicated sensitive records also (initial):

Mental Health Records ____

HIV or AIDS . . . . . .____

Chemical Dependency ___

Genetic Information _____

4. Extent or nature of records to be released:
☐ All records
☐ Specific hospitalization(s) or visit(s) dated:
_____

5. Purpose of disclosure: ☐ Continuity of Care ☐
   Other:_____

6. This authorization shall be in effect for 12 months following the date of signature.

7. I understand that I may revoke this consent at any time by notifying the providing organization in writing, though it may not prevent action that has already been taken.

8. I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

9. I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services received.

10. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

11. A photocopy is as valid as the original.

Signature of Patient/Guardian: _____ Date: _____

Relationship to patient if unable to sign: _____ Witness: _____

Have you *recently* had any of the following (circle or underline all that apply)?

Constitutional

fever , night sweats , weight gain (___lbs) , weight loss (___ lbs) , exercise intolerance

Eyes

dry eyes , irritation , vision change

ENMT

difficulty hearing , ear pain

frequent nosebleeds , nose/sinus problems

sore throat , bleeding gums , snoring , dry mouth , oral abnormalities , mouth ulcer , teeth abnormalities , mouth breathing

Cardiovascular

chest pain with activity, arm pain with activity, shortness of breath when walking , shortness of breath when lying down , palpitations , known heart murmur , light-headed on standing

Respiratory

cough , wheezing , shortness of breath , coughing up blood , sleep apnea

Gastrointestinal

abdominal pain , vomiting , change in appetite , black or tarry stools , frequent diarrhea , vomiting blood , dyspepsia , reflux

Genitourinary

urinary loss of control , difficulty urinating , increased urinary frequency , hematuria , incomplete emptying

Musculoskeletal

muscle aches , muscle weakness , joint pain (location_____), back pain , swelling in the extremities

Integumentary

abnormal mole , jaundice , rash , itching , dry skin , growths/lesions

Neurologic

loss of consciousness , weakness , numbness , seizures , dizziness , frequent or severe headaches , migraines , restless legs

Psychiatric

depression , anxiety , sleep disturbances , restless sleep , feeling unsafe in relationship , alcohol abuse

Endocrine

fatigue , increased thirst , hair loss , increased hair growth , cold intolerance

Hematologic/Lymphatic

swollen glands , easy bruising , excessive bleeding

Allergic/Immunologic

runny nose , sinus pressure , itching , hives , frequent sneezing

Other: Please list

□ None of the above