Confidential Patient Information

730 SE Oak St. Suite K, Hillsboro, OR 97123
Ph:503.430.1057 Fax:503.430.1085 Website: www.nwppc.com

Name:____ Date: __________ Age:_____
Last First M.I.

Date of Birth:________________ Gender: F M

Physical Address:____
Street/ P.O. Box City State Zip Code

Mailing Address:____
Street/ P.O. Box City State Zip Code

Phone: Home:____________________Cell:_____________________Work:________________

Preferred Contact #: **(Please circle one)** Home Cell Work

Do you give permission to NWPPC to leave a message with Protected Health Information: Yes No

If yes, please circle what phone numbers we are able to leave detailed messages on: Cell Home Work

Occupation:_________________________ Children: Yes No How many:____________

Marital Status: Single:_______Married:_______Divorced:_______Other:_______

Do you live with: Partner/Spouse:_____Friends:_____Parents:_______Alone:_______Children:_______

<u>INSURANCE INFORMATION</u>

Company:________________________ID #:_________________Group #:________________

Effective Date:___________________Plan Year:___________________Deductible:___________

Please provide primary insurer's information if different than the patient: Relationship to patient:________

Insurer's Name:__________________________________Date of Birth____________________

Address:____Phone #:__________________

Emergency Contact Information:

____
Name Relation to patient Telephone number

<u>PHARMACY INFORMATION</u>

Name:____Address:_________________________

Phone:___________________________________Fax:______________________

ALLERGIES ____

What are your most important health problems? List as many as you can in order of importance.

1.__________________________ 4. ________________________
2.__________________________ 5. ________________________
3.__________________________ 6. ________________________

How did you hear about us?____

Consent and Policy Agreement

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Medical Consent: My care as a patient is directed by a licensed supervising physician. I consent to services rendered and provided to me under the instruction of supervising staff physicians.

CONSENT FOR RELEASE OF INFORMATION
Release of Information to Physician, Referring Physician, Insurer, and Professional Review Organization: I authorize release of medical and related information, including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

Social Security numbers: Are not collected. If given, it is for the purpose of patient identification, compliance with federal and state agency reporting requirements, and billing to insurance carriers and collection needs. Disclosure of the social security number information is voluntary. If I have provided this information, I authorize release for the purpose stated above.

STATEMENT OF FINANCIAL RESPONSIBILITY
Financial Agreement: The undersigned, jointly and severally, in consideration of services to be rendered to patient, agree to pay each provider of service, in accordance with their regular rates and terms, for the services rendered. The undersigned further agrees to pay reasonable attorney fees and expenses incurred in collecting all sums not paid when due, whether or not litigation is actually commenced, as well as all attorney fees and costs on appeal. The undersigned assigns to each provider of service all insurance benefits available for their professional and clinic services rendered. The assignment is irrevocable, and the undersigned authorizes carrier of said benefits to make payment directly their practitioner or other related billing services. Payments received from insurers will apply to the patient's account balance obligation. The undersigned agrees to promptly pay any charges that are not immediately (within 30 days) covered by insurance. Quoted benefits and/or payment from insurance companies are not a guarantee of coverage. ***It is the responsibility of the insured to verify benefits and coverage from their insurance company.***

FINANCIAL POLICY
I have reviewed and agree to the Financial Policy terms. **Initials________**

HIPAA PRIVACY POLICY
I have been given the opportunity to review the "HIPAA" privacy policy. **Initials _______**

EMAIL POLICY
I understand that email is not secure for Personal Health Information (PHI) exchange and acknowledge that any emails sent to and from my provider are not protected under HIPAA. Providers do not initiate new email exchange, but can reply if initialed. Patient Ally is secure for PHI exchange. **Initials _______**

- **Email Address: ____**

I agree to the above consents, authorizations to release information, financial agreement, and HIPAA privacy policies that apply to the medical services provided for two years from the date shown below.

I have read, fully understand, and agree to the above statements.

____
Patient Signature Date

____
Parent, Guardian, Responsible Party, Legal Representative

____
Patient PRINTED name