Hillsboro Clinic

356 SE 9th Ave, Hillsboro, OR 97123

PATIENT INFORMATION

Patient's Legal Name: _____
Last Name First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (circle one): Home / Cell _____ Phone (circle one): Home / Cell _____

Email:_____

Date of Birth: _____ ☐ Male ☐ Female Social Security #: _____-_____-_____

Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: _____

Phone # (circle one): Home / Cell _____

EMPLOYER

Patient's Employer: _____ Work Phone: _____

Occupation: _____

EMERGENCY CONTACT

Contact (not living with patient): _____ / _____
Relationship to patient

Phone # (Circle One): Home / Cell _____

If patient is under 18 – **PARENT'S NAMES** and daytime phone numbers:

FATHER: _____

Phone # (circle one): Home / Cell _____

MOTHER: _____

Phone # (circle one): Home / Cell _____

Authorization: I Father/Mother/Legal Guardian herby authorize the above Physician's Office to contact the emergency contact person above and speak to them regarding your current address and phone #. I also authorize the above Physician's Office to provide 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_____
(Patient's signature – must be signed by parent-guardian if patient is under the age of 16)

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BILLING INFORMATION

PRIMARY Insurance: _____

Subscriber's Legal Name: _____ / _____
Last Name First Middle Relationship to Patient

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (circle one): Home / Cell _____

Alternate Phone # (circle one): Home / Cell _____

Date of Birth: _____ ☐ Male ☐ Female Social Security #: _____-_____-_____

Subscriber's Employer: _____ Occupation: _____

Employer's Phone: _____

_____

Secondary Insurance: _____

Subscriber's Legal Name: _____ / _____
Last Name First Middle Relationship to Patient

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Phone # (circle one): Home / Cell _____

Alternate Phone # (circle one): Home / Cell _____

Date of Birth: _____ ☐ Male ☐ Female Social Security #: _____-_____-_____

Subscriber's Employer: _____ Occupation: _____

Employer's Phone: _____

Hillsboro Clinic
356 SE 9th Avenue
Hillsboro, OR 97123

PLEASE READ AND SIGN BELOW

- *Payments for any services you receive here at our Clinic are your responsibility. We will bill your insurance, but full payment even in legal actions, motor vehicle accidents, on the job injuries, children of divorced parents, and insurance disputes will be your responsibility.*
- *All private pay patients are required to pay in full at the time of the visit. You may pay with cash, check, Visa or MasterCard. Please make arrangements for a payment plan if necessary with our billing office.*
- *If your insurance plan requires a co-payment, it will be collected at time of service.*
- *Current proof of medical coverage must be presented at the front reception desk. Failure to present current coverage will delay your appointment while we verify coverage.*
- *Account balances are due and payable within 60 days from the date of service. All payment arrangements must be made through the billing office.*
- *Outside X-ray/Laboratory testing: Your medical treatment may require testing through and outside facility. When tests are performed by an outside facility, charges for these services will be handled by the facility performing the tests.*
- *Your Prescription refills will be handled more efficiently when you notify your Pharmacy at least 3 days prior to the end of you medication.*
- ***Please notify our clinic 24 hours in advance if you must cancel an appointment. Failure to cancel an appointment in advance may result in a $25.00 "No-Show" charge. (Failure to "No-Show" 3 times, may result in a request for you to seek medical treatment at another facility.) Please be courteous to our other patients and let us know if you are unable to keep your appointment. Thank you.***

Signature of Patient/
Responsible Party _____*Date*_____

ACKNOWLEDGMENT AND CONSENT

I understand that Hillsboro Clinic (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:

1. make decisions about and plan for my care and treatment;
2. refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
3. 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 or all of my health care; and
4. 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 Privacy Practices. 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 and available to read in notebook form.

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 <u>have received</u> a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)
Description of Representative's Authority:_____