HILLSBORO CLINIC
Excellence in Primary Care

356 SE 9th Ave
Hillsboro, OR 97213
www.HillsboroClinic.com
503.681.4366 (teléfono)
503.681.4374 (fax)

Paquete para nuevos pacientes

Marc Lewis, MD Anne Dunne, NP Caitlin Hale, PA-C

INFORMACIÓN DEL PACIENTE **Paciente ID #:** _____ **Género: [ ] M [ ] F**

Nombre: _____ **Fecha de nacimiento:** _____

Direccion: _____ **Seguridad Social #:** _____

Ciudad, Estados, Código postal: _____ **Marital Status: [ ] Casado [ ] No Casado [ ] Divorciado**

Teléfono: _____ **[ ] Casa [ ] Trabajo [ ] Otro** **Correo Electrónico:** _____

_____ **[ ] Casa [ ] Trabajo [ ] Otro** **Médico remitente:** _____

_____ **[ ] Casa [ ] Trabajo [ ] Otro** **Farmacia preferida:** _____

Etnicidad: [ ]Hispanic or Latino [ ]Non-Hispanic or Latino [ ]Other

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Other Pacific Islander [ ] White or Caucasian [ ] Other or Undetermined

INFORMACIÓN DE EMPLEO PARA PACIENTES

[ ] Empleado [ ] Retirado [ ] Desempleados [ ] Otra

Nombre del empleado: _____

Teléfono del empleador: _____

Ocupación: _____

CONTACTO DE EMERGENCIA

Nombre	Relación	Teléfono

Persona responsable **(si el paciente es menor de 18 años)**

Nombre: _____

Direccion: _____

_____

Ciudad, Estados, Código postal: _____

Empleador: _____

Teléfono: _____

Teléfono del trabajo: _____

SSN: _____

Fecha de nacimiento: _____

SEGURO PRIMARIO

Nombre del seguro: _____

ID #: _____

Group/Policy ID #: _____

Nombre del asegurado: _____

Asegurado DOB: _____

SEGURO SECUNDARIO

Nombre del seguro: _____

ID #: _____

Group/Policy #: _____

Nombre del asegurado: _____

Relación: _____

AUTORIZACIÓN Y ASIGNACIÓN DE SEGUROS (Por favor lea y firme)

Doy fe de que la información que he proporcionado aquí es correcta y verdadera según mi leal saber y entender. Por la presente, asigno los beneficios que se pagarán directamente al proveedor médico y autorizo a proporcionar información sobre mi enfermedad a mi compañía de seguros. Entiendo que soy responsable de cualquier monto no pagado por mi seguro. *Autorizo a la clínica a obtener electrónicamente el historial de medicamentos del administrador de beneficios de mi farmacia.*

PATIENT/GUARDIAN SIGNATURE DATE

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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: _____

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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 will result in a $50.00 "No-Show" charge for an office visit. If you "No-Show" a Wellness Exam it will be $100.00. These no show will be collected before any other appointments will be made. (If you "No-Show" 3 times, it 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: _____

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PATIENT RESPONSIBILITY NOTICE WAIVER FORM

Patient Name: _____

Hillsboro Clinic provides many different types of medical services including exams, labs, minor surgical procedures, testing, and general medical care. Although most insurance companies cover a percentage of most services, there are some insurance companies that do not cover certain types of procedures.

Our staff makes every effort to assist you in understanding your medical health benefits. However, it is impossible for us to know all the policies for all the many insurance plans available. Therefore, we are providing this Notice to inform you of the following responsibilities as they relate to benefit coverage and payment responsibilities by the patient and Hillsboro Clinic.

Hillsboro Clinic Responsibilities:

Hillsboro Clinic is not responsible for knowing what services are covered by the patient's insurance plan and is not responsible for informing the patient whether a particular service is covered. Hillsboro Clinic will assist the patient in obtaining payment from his/her insurance company by submitting the necessary insurance claims.

Patient's Responsibilities:

If is the patient's responsibility to know and understand his/her own medical insurance benefit coverage and limits. The patient is ultimately responsible for payment for all services rendered by Hillsboro Clinic, and the patient must pay for any services not covered by the patient's insurance company.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of the Hillsboro Clinic and accept that Hillsboro Clinic is not responsible for knowing my medical insurance benefits for services provided.

_____ _____

Signature of Responsible Party Date

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Nombre: _____
Fecha de nacimiento:_____

Cuestionarios sociales: Encierra en un círculo o escribe tus respuestas.
Marital Status: Casado No Casado Divorciado Viudo Other_____

Cuantos hijos tienes? _____

Cual es tu ocupación? _____

¿Con quién vives actualmente?_____

Planificación avanzada de la atención:

¿Tiene un poder médico? Si No

¿Tiene usted una directiva anticipada? Si No

ejercicio:

¿Cuál es tu nivel de ejercicio? de nada ocasional moderada pesada

¿Cuántas veces por semana haces ejercicio (días por semana)? <1 1-2 3-4 5-7

dieta: Califica tus hábitos de alimentación saludable. Excelente Bueno Justo Pobre

¿Qué tipo de dieta sigues? Regular vegetariano vegano GF Diabetes

¿Fuma o ha fumado tabaco? SI NO
¿Consume alguna forma de tabaco o nicotina? tipo:
¿A qué edad empezaste a fumar?
¿Cuándo dejaste de fumar?

Pantalla auditiva: (50 años y más)
¿Tiene problemas para oír cuando otros no? SI NO
Te esfuerzas por escuchar y comprender las conversaciones? you strain to hear/ understand conversations? SI NO

Examen de control de la vejiga: (50 años y más)
¿Tiene algún problema con la pérdida de orina? SI NO
¿Le gustaría discutir opciones? SI NO
Preguntas sobre el sueño (30 años o más):
¿Tu sueño es suficiente? SI NO ¿Cuántas horas duermes? _____
¿Tomas siestas? SI NO ¿Con qué frecuencia? Regularmente Ocasional
¿roncas? SI NO ¿Tienes apnea del sueño? SI NO
¿Tienes somnolencia diurna? SI NO
¿Tomas algún medicamento para dormir? SI NO
¿Son útiles los medicamentos? SI NO N/A

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Historial médico personal: Circule cualquier condición que tenga

ADD/ADHD	Alcoholism	Allergies/Hayfever	Anemia
Anxiety Disorder	Arthritis	Asthma	Birth Defects/Inherited
Blood diseases	Breast Cancer	Cancer: _____	Colon Cancer
Congestive Heart Failure	Dementia/Alzheimer's	Depression	Development/Behavioral Disorder
Diabetes: Type_____	Eczema (Chronic Rash)	Headaches (Migraines)	Heart Disease (Valve)
Heart Disease (Attack)	Heart Rhythm Problems	High Cholesterol	High Blood Pressure
High Thyroid Levels	Low Thyroid Levels	Infertility	Kidney Disease
Obesity	Osteoporosis	Ovarian Cancer	Polyps (colon)
Seizures/Epilepsy	Skin Cancer	Stroke	Thrombophilias (bleeding disorder)

Por favor enumere cualquier alergia nueva.:

_____

_____

Indique si le han recetado algún medicamento nuevo de otros proveedores?

_____

_____

Proporcione cualquier otro especialista del que reciba atención activamente y qué tipo de atención recibe.

Nombre y especialidad/tipo de proveedor:

_____
_____
_____

Tipo de cuidado:

_____
_____
_____

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Nombre: _____

Fecha de nacimiento:_____

Historia familiar: Identifique las condiciones que se aplican a las de los miembros de la familia enumerados. Por favor identifique si es Abuelo Paterno o Materno.

Disorder:	Padre	Madre	Hermano	Hermana	Hijo	Hija	Abuela (P/M)	Abuelo (P/M)
Alcohol Abuse								
Alzheimer's								
Anemia								
Arthritis								
Asthma								
Blood Coagulation disorder								
Cerebrovascular incident								
Dementia								
Depressive disorder								
Diabetes								
Disease of liver								
Disorder of thyroid								
Heart Disease								
High Cholesterol								
High Blood Pressure								
Uterine Cancer								
Breast Cancer								
Cervical Cancer								
Colon Cancer								
Ovarian Cancer								
Migraine								
Osteoporosis								
Seizure Disorder								