

HILLSBORO CLINIC

Excellence in Primary Care



356 SE 9th Ave.
Hillsboro, OR 97123
www.hillsboroclinic.com
503-681-4366 (Phone)
503-681-4374 (Fax)

Dr. Marc Lewis

Anne Dunne, DNP

Caitlin Hale PA-C

Patient: _____

DOB: _____

Thank you for attending your annual health maintenance exam. Depending on your health insurance plan, you may receive preventative benefits for a reduced or no co-pay. We would like to clarify the services covered as preventative benefits and what can and cannot take place during your visit to avoid additional charges.

Covered:

- Age/Gender focused exam
- Advice for disease prevention and healthy living
- Discussions about previously identified risk factors (i.e. smoking)
- Lab/Imaging test to screen for diseases for which you may be at risk due to age, gender, or lifestyle
 - Labs are LIMITED to screening conditions not already diagnosed.
- Standard age-based immunization

Non-Covered:

- New problems that require prescription medication
- New problems that require lab test, images or other evaluation
 - This includes lab to check on status of current conditions
- Minor Procedures (i.e. skin tag removal, wart treatment)
- Chronic problems that require management strategies and changes to plan of care
- Immunizations specific for traveling

You may schedule a separate appointment to address new problems or unstable chronic conditions. On the other hand, if you make an appointment for a health maintenance visit and have additional concerns, your provider may want to focus on your concerns first and defer the health maintenance visits until another appointment. Non-preventative issues could result in additional charges for the test or office visit. In many cases, we provide more than the basic requirements in order to provide more complete care. Please note that this handout does not completely define our inclusions and exclusions.

As a patient of the Hillsboro Clinic I understand that any and all charges associated with the cost of a routine Health Maintenance physical exam may not be covered by my health insurance carrier if I discuss any of the above mentioned Non-covered services with my provider during the exam. I also understand that any and all diagnostic tests ordered by my provider and performed as a result of current health issues discussed during my exam may NOT be covered by insurance. If my insurance does not cover these services I may be held financially responsible for the charges related to these services.

Name: _____ Date: _____

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PATIENT: _____ DOB: _____

AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

I authorize Hillsboro Clinic to use and disclose a copy of the specific health and medical information described below regarding: _____

(Name of Patient)

consisting of any and all medical records, including billing, to:

(Name of Recipient or Class of Recipients)

(Recipient's Relationship to Patient)

(Recipient's Phone Number)

for the purpose of coordination of patient care.

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: (1) Creating health information about you to be disclosed to a third party; or (2) for the purpose of research.

You have the right to revoke this Authorization at any time, provided that you do so in writing. 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. To revoke this Authorization, please send a written statement to Hillsboro Clinic that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and state that you are revoking this Authorization.

This Authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date: _____
(Patient Signature)

-OR-

By: _____ Date: _____
(Patient Signature)

Description of Representative's Authority: _____



New Patient Packet

Dr. Marc E. Lewis

Anne Dunne, FNP

Caitlin Hale, PA-C

PATIENT INFORMATION

Name: _____ Date of Birth: _____
 Sex: Male Female
 Address: _____ Gender Identity: _____ Pronouns: _____
 City, State, Zip: _____ Social Security #: _____
 Phone: _____ Home Work Other Marital Status: Married Single Divorced
 _____ Home Work Other Email Address: _____
 _____ Home Work Other Preferred Pharmacy: _____
 Preferred Language: _____
 Ethnicity: 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

PATIENT EMPLOYMENT INFORMATION

Employed Retired Unemployed Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

RESPONSIBLE PARTY (if patient is under 18 years of age)

Name: _____

Address: _____

City, State, Zip: _____

Employer: _____

Home Phone: _____

Work Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

Insurance Co. Name: _____

ID #: _____

Group/Policy ID #: _____

Subscriber's Name: _____

Subscriber's DOB: _____

SECONDARY INSURANCE

Insurance Co. Name: _____

ID #: _____

Group/Policy #: _____

Subscriber's Name: _____

Relationship to Patient: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. *I understand that I am responsible for any amount not paid for by my insurance. I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.*

 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 have received 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:

It 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



Social Questionnaires: Circle or write your answers.

Marital Status: Single Married Separated Divorced Widowed Other _____

How many children do you have? _____

What is your occupation? _____

Who do you currently reside with? _____

Advance Care Planning:

Do you have a medical power of attorney? YES NO

Do you have an Advance Directive? YES NO

Exercise:

What is your exercise level? None Occasional Moderate Heavy

How many times per week do you exercise? Less than 1 time per week

1-2 times per week 3-4 times per week 5-7 times per week

Diet:

Rate your healthy diet habits. Excellent Good Fair Poor

What type of diet are you following? Regular Vegetarian Vegan Gluten Free

Carbohydrates Cardiac Diabetic

Do you or have you ever smoked tobacco? YES NO

Do you or have you ever used any other form of tobacco or nicotine? Type:

At what age did you start smoking tobacco?

When did you quit smoking?

Hearing Screen: (Age: 50+ Only)

Do you have trouble hearing the television or radio when others don't? YES NO

Do you strain to hear/understand conversations? YES NO

Bladder Control Screen: (Age: 50+ only)

Do you have trouble with urinary leakage? YES NO

If yes, would you like to discuss options? YES NO

Sleep Health: (Age: 30+ only)

Is your sleep sufficient? YES NO How many hours per night do you sleep? _____

Do you take naps? YES NO How often? Regularly Occasionally No naps

Do you snore? YES NO Do you have sleep apnea? YES NO

Do you experience daytime sleepiness? YES NO

Have you tried any medications for sleeping? YES NO

Were the medications you tried helpful? YES NO N/A



PERSONAL MEDICAL HISTORY: CIRCLE ANY CONDITIONS FOR WHICH YOU HAVE.

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)

Please list if you have any new allergies:

Please list if you have been prescribed any new medications from any outside providers?

Please provide any other specialist that you actively receive care from and what type of care that you receive.

Name and Specialty/Provider Type:

Type Of Care:

Patient Health Questionnaire

Date _____ Patient Name: _____ Date of Birth: _____

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

**Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.**

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all

Somewhat difficult

Very Difficult

Extremely Difficult

Substance Screening

Name: _____
Date of Birth: _____

Circle your answers

How often did you have a drink containing alcohol in the past year?

- Never Monthly or less 2-4 times a month
2-3 times a week 4 or more times a week

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

- 0 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often did you have 6 or more drinks on one occasion in the past year?

- never less than monthly monthly weekly
daily or almost daily

Steady Falls Risk (circle your answer)

- | | | |
|--|-----|----|
| Have you fallen in the past year? | YES | NO |
| Do you use or have you been advised to use a cane or walker? | YES | NO |
| Do you sometimes feel unsteady while walking? | YES | NO |
| Do you feel steady yourself by holding onto furniture when walking at home? | YES | NO |
| Do you worry about falling? | YES | NO |
| Do you need to push with your hands to stand up from a chair? | YES | NO |
| Do you have trouble stepping up onto a curb? | YES | NO |
| Do you often have to rush to the toilet? | YES | NO |
| Have you lost some feeling in your feet? | YES | NO |
| Do you take medicine that sometimes makes you light headed or more tired than usual? | YES | NO |
| Do you take medicine to help you sleep or improve your mood? | YES | NO |
| Do you often feel sad or depressed? | YES | NO |