HILLSBORO CLINIC
Excellence in Primary Care

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

DR. MARC E. LEWIS DR. MEENAKSHI AGGARWAL ANNE DUNNE, DNP MELINDA SANFILIPPO, FNP

PATIENT INFORMATION

Patient's Legal Name: _____
Last Name First Name Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____

Email: _____

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

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

Spouse's Name: _____

Phone: Home _____ Cell _____

EMPLOYER

Patient's Employer: _____ Work Phone: _____

Occupation: _____

EMERGENCY CONTACT

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

Phone: Home _____ Cell _____

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

FATHER: _____

Phone: Home _____ Cell _____

MOTHER: _____

Phone: Home _____ Cell _____

Authorization: I Father/Mother/Legal Guardian hereby authorize the above Physician's Office to contact the emergency contact person above and speak to them regarding your current address and phone number. 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 Name Middle Relationship to Patient

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____

Alternate Phone: 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 Name Middle Relationship to Patient

Subscriber's Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home _____ Cell _____

Alternate Phone: Home _____ Cell _____

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

Subscriber's Employer: _____ Occupation: _____

Employer's Phone: _____

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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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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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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

Thank you for choosing Hillsboro Clinic Family Practice as your primary healthcare provider. We are a competent and experienced group of health care professionals who strive to provide the best health care for you and your family. We care for patients of all ages, including newborn infants, at Hillsboro Clinic.

We address the health care needs of babies, children, teenagers and adults – physical, social and emotional. This takes time, concentration and sometimes repeat visits.

We do our best to give each patient the attention they need, and to keep waiting times as short as possible. We thank you for your patience while visiting Hillsboro Clinic Family Practice.

HOURS OF OPERATION

Monday	7:00am – 5:00pm
Tuesday	8:00am – 6:00pm
Wednesday	7:00am – 5:00pm
Thursday	8:00am – 6:00pm
Friday	8:00am – 5:00pm
Saturday	closed
Sunday	closed

Phones Open Mon – Fri 8:00am – 5:00 pm

(503) 681-4366*

356 SE 9th Ave Hillsboro, OR 97123

www.HillsboroClinic.com

*A medical provider is available at this number after hours for emergency calls only.

We respect the privacy rights of our patients. Information about patient rights can be found on our website under "Forms & Information".

For complaints or grievances regarding any aspect of office operations, please complete the form on our website or contact the Office Manager.

503-681-4366 ext: 206

HILLSBORO CLINIC

Excellence in Primary Care

Serving patients in Washington County and beyond since 1995. We look forward to helping your medical needs.

CALL 503-681-4366

We know that you have options for health care providers, and we appreciate your trust placed with us. Our goal is to respect each patient and caregiver, and to achieve excellent health for our patients.

Dr. Marc E. Lewis, MD has been serving patients in Oregon as a board-certified family physician since 2000. He has served as Medical Staff President of Tuality Community Hospital, and chaired the Medical Executive Committee. Currently, Dr. Lewis is serving on the Tuality Health Alliance Executive Board as well as an expert witness for the Oregon Medical Board. He served on the Tuality Hospitals Board from 2008 to 2014. He has served as chair of the Tuality Hospital Quality Management Committee, and Family Practice Physician Group.

Dr. Meenakshi Aggarwal, MD trained initially and practiced in Obstetrics and Gynecology. Over the years, she was attracted to the full spectrum of care that a family physician can provide. She expanded her training by completing a three-year Family Medicine Residency at Emory University in June 2009, and brought her expertise in Gynecology and Family Medicine to Hillsboro Clinic shortly thereafter. Her areas of special interests include Women's Health and Preventive Medicine.

Anne Dunne, DNP completed her Doctorate of Nursing Practice degree through Indiana State University in 2019. Her initial nurse training was in Great Britain before she moved to the United States in 1991. Her areas of clinic experience include Neonatal Intensive Care and kidney dialysis. During her early years in the United States, she completed a Bachelors of Science and Nursing degree through the University of Phoenix. She earned her Masters of Science degree from Indiana State University in 2013. She joined the Hillsboro Clinic team in 2014. Her areas of interest include women's health and preventative care.

Melinda Sanfilippo, FNP is a board-certified Family Nurse Practitioner (FNP). She has been a licensed healthcare provider since 1976 and continues to make patients her focus. She worked in various venues such as oncology, motherbaby, hospital, rehab, assisted living, and home health. In 2003 she earned her Master's degree from the University of Phoenix in nursing along the educational and administrative track. She then went into nursing education and taught both LPNs and RNs nursing skills for over 12 years at Carrington College, Breckenridge School of Nursing and Oregon Technical Institute in Salem. In 2014 she earned her Family Nurse Practitioner certification from Graceland University.

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GRIEVANCE AND COMPLAINTS RECORD FORM

PART A: RECORD OF COMPLAINT

Date of complaint: _____ / _____ / _____

Details of person raising complaint:

Name: _____ Phone: _____

Address: _____ Email: _____

Details of advocate (if applicable):

Name: _____ Phone: _____

Address: _____ Email: _____

Details of staff or committee member taking complaint:

Name: _____ Phone: _____

Address: _____ Email: _____

Nature of the grievance/complaint:

Date(s) occurred: _____

Other parties involved: _____

Details: _____

_____

_____

_____

_____

_____

_____

_____

_____

Details of actions to date to address the concern: _____

_____

_____

_____

_____

_____

_____

_____

_____

Desired outcome of process: _____

_____

_____

_____

Signed: _____ Signed: _____

(person making complaint) (person receiving complaint)

Date coordinator informed: _____ / _____ / _____ by _____

Date management committee informed _____ / _____ / _____ by _____

PART B: RECORD OF COMPLAINT RESOLUTION

Actions to be taken:

Details of Task	Who is responsible?	By when?	Completed?

Records of Meetings/Phone Calls:

Date	Type of Contact	People Involved	Key Issues Discussed	Decisions Made

Details of External Review (if applicable):

Name: _____ Organization: _____

Phone: _____ Email: _____

Recommendations from external review: _____

_____

_____

_____

Outcomes of resolution process: _____

_____

_____

_____

_____

_____

_____

Has the complaint been resolved? Yes No

Signatures upon resolution:

Person raising complaint: _____ Date: _____ / _____ / _____

Coordinator: _____ Date: _____ / _____ / _____

Chairperson: _____ Date: _____ / _____ / _____