# 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 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 _____

Demographics

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Non Hispanic or Latino ☐ Hispanic or Latino ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Do you need use of an interpretor? ☐ YES ☐ NO

## 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: _____

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**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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# 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:

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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Social Questionaires: 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 None
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?
At what age did you start smoking tobacco?
When did you quit smoking?

Hearing Screen:
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:
Do you have trouble with urinary leakage? YES NO
If yes, would you like to discuss options? YES NO

Sleep Health:
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

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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?

_____

_____

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Name: _____

Date of Birth: _____

Family History: Please identify conditions that apply to those of family members listed. Please identify if it is Paternal or Maternal Grandparent.

| Disorder: | Father | Mother | Brother | Sister | Son | Daughter | Grandmother (P/M) | Grandfather (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 | | | | | | | | |

**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:**

_____ _____

_____ _____

_____ _____

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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 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:_____