HILLSBORO CLINIC
Excellence in Primary Care

356 SE 9th Ave
Hillsboro, OR 97123
www.HillsboroClinic.com
503.681.4366 (phone)
503.681.4374 (fax)

Marc Lewis, MD Meenakshi Aggarwal, MD Anne Dunne, DNP Caitlin Hale, PA-C Melinda Sanfilippo, FNP

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:_____

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New Patient Ages 0-11 Packet

Dr. Marc E. Lewis Dr. Meenakshi Aggarwal Anne Dunne, FNP Caitlin Hale, PA-C Melinda Sanfilippo, FNP

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 <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

HILLSBORO CLINIC
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Name: _____

Date of Birth:_____

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?

_____

_____

HILLSBORO CLINIC

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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:**

_____ _____

_____ _____

_____ _____