PMC Physicians' Medical Center, PC

2435 NE Cumulus Ave., Suite A, McMinnville, OR 97128Phone: 503-472-6161 Fax: 503-434-6290

NEW PATIENT INFORMATION

Office Hours:
Monday through Friday 8:30 a.m. to 5:30 p.m., with
Saturday Clinic Hours: 8:30 a.m. to 12:00 p.m. (Acute Care)

Lab Hours:
Monday through Friday 8:30 a.m. to 5:30 p.m.
Saturday 9:00 a.m. to 12:00 p.m.

Business Office Hours:
Monday through Friday 8:30 a.m. to 5:30 p.m.

X-Ray Hours:
Monday through Friday 9:00 a.m. to 5:30 p.m.
(Closed 12:30 p.m. to 1:30 p.m.)

Prescriptions:
After your initial visit you can request a refill on your prescription by calling your pharmacy. We ask that you give us 48 – 72 hours to complete your pharmacy's request.

After Hours:
Call 503-472-6161 for on-call physician information.
Call 503-883-8602 for the Answering Service Attendant.

Parent/legal guardian must accompany all new patients under the age of 18. Legal guardians must provide a copy of guardianship documentation at the time of the visit.

Foster Parent must accompany all new patients under the age of 18. Foster parents must provide a copy of the placement letter at the time of visit.

You will be asked by reception for photo identification and insurance card at the time of each visit to comply with Federal Trade Commissions' Theft Prevention Red Flag Rule.

We offer a website and Patient Portal that allows you access to portions of your medical record as well as communication between you and your healthcare provider, test results, ability to ask a billing question, request an appointment and much more.

Chronic Pain Pathway at PMC

Physicians' Medical Center has created the Pain Pathway in concordance with state guidelines and CDC recommendations. Any new patient entering the practice with an established chronic pain treatment plan that includes opioid or narcotic medications (including but not limited to: hydrocodone, oxycodone, morphine, tramadol, fentanyl) should be aware of the following:

- Safety:
  - CDC reports that opioids killed more than 28,000 people in 2014, more than any year on record. Since 1999, the number of overdose deaths involving opioids nearly quadrupled. From 2000 to 2014 nearly half a million people died from drug overdoses. 78 Americans die every day from an opioid overdose. https://www.cdc.gov/drugoverdose/epidemic/index.html

- PMC requirements for chronic narcotic use:
  - Controlled substance contract
  - Random urine drug screens with a minimum of 2/year
  - Up to quarterly office visits to review pain, function and medication
  - One individual visit with our behavioral health consultant
  - Participation in 4 pain school classes
  - Receive pain medication from PMC only and use on pharmacy
  - No marijuana use with narcotic prescriptions
  - Give 48 hours' notice for refill requests (not on weekends)
  - Bring pill bottles with you to every appointment
  - Naloxone training may be required

- PMC Goals of Pain Pathway:
  - Maintain safety of patients at all times
  - Optimize function with appropriate treatment for pain
  - Use of lowest possible dose of any narcotic prescription

*****PMC reserves the right not to fill a narcotic prescription on your first visit*****

Physicians' Medical Center, P.C.

Notice: Patient Privacy

***

We are required by law to protect the privacy of your medical information and to provide you with written NOTICE describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

* We may use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment for reimbursement of the care that we provided to you, and the related administrative activities supporting your treatment.

* We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

* As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures or your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

* We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.

* You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.

* If you have any questions, concerns or complaints about this NOTICE or your medical information, please contact our PRIVACY OFFICER at (503) 472-6161.

Effective Date 4-14-03

Financial Policy

PHYSICIANS MEDICAL CENTER P.C.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the patient due balance, any charges still pending insurance, the rebilling fee, if any, and any payments or credits applied to your account.

If you have no insurance: You are to pay by __cash, __check, or __credit card on the day that treatment is rendered. If you are not able to make full payment and must be seen today (urgent), you will be expected to make payment arrangements with our Business Office.

If you have insurance: You are to pay by __cash, __check, or __credit card on the time of service for your co-pay. Any co-pays required by an insurance company must be paid at the time of service. If you cannot pay for co-pays at time of service an $8.00 fee will be assessed.

Payments: Unless other arrangements have been made with the Business Office, the balance on your statement is due and payable when the statement is issued, and is past due if not paid in 60 days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Insurance: It is your responsibility to monitor your benefits and annual maximum. We will be happy to assist you with any resubmissions. The insurance company makes the final determination of your eligibility. You agree to pay any portion of the charges not paid by insurance. If you have an HMO plans it is your responsibility to know and understand your HMO plan. Generally, these plans require payment of co-payment at time of service.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Workers Compensation: We will bill your workers comp insurance if you provide us with that information. You will need to fill out an 827 with us. If your claim is denied, you will be responsible for payment in full. If you notify us that an injury happened at work and then decide not to claim it as an on the job injury we are legally responsible to notify your workers compensation insurance.

Waiver of Confidentiality: You understand if this account is submitted to a collection agency and your past due balance is reported to a credit-reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

PHYSICIANS' MEDICAL CENTER, PC - PATIENT INFORMATION

PLEASE PRINT

Name: _____

Address: _____

_____

City,State,Zip: _____

Phone: _____ [ ]Home [ ]Work [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Other

Email: _____

Consent for eMed History: Y N

Doctor: _____

Patient ID #: _____ **Sex:** [ ]M [ ]F

Date of Birth: _____

Social Security #: _____

Race: _____ **Ethnicity:** _____

Marital Status: [ ]Married [ ]Single [ ]Divorced

Alternate Parent/Contact: _____

Primary Physician: _____

Preferred contact: **[ ] Phone [ ] Email**

RESPONSIBLE PARTY/GUARDIAN INFORMATION

[ ]Same as Patient

Name: _____

Address: _____

_____

City,State: _____

Phone 1: _____ **Phone 2:** _____

EMPLOYMENT

Employer: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Ins Company: _____

Patient Relationship to Insured Party: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: _____

Insured Phone: _____

Company: _____

Patient Relationship to Insured Party: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

PLEASE READ THIS STATEMENT CAREFULLY AND SIGN AT THE BOTTOM

The information I have provided is complete and true to my knowledge. I hereby authorize Physicians' Medical Center, PC and my insurance company to exchange any information either party may request concerning my claims and care. I also authorize all insurance payments to be assigned directly to Physicians' Medical Center, PC. I acknowledge that I am financially responsible for payment of all charges whether or not they are covered by my insurance. By signing below I agree to the following conditions:

* Account balances over 60 days will be assessed a monthly rebilling fee of $8.00.
* NSF checks will be charged $25.00.
* Co-pays not made at the time of service will be charged an additional $8.00 processing fee.
* Disability and time-loss forms will be charged $25.00 when not completed by the physician at the time of an office visit.
* Delinquent accounts will be assigned to a credit reporting collection service and I will be responsible for all collection activity expenses including reasonable attorney fees.
* Physicians Medical Center PC reserves the right to terminate me from the practice for failure to comply with these conditions.
* Failure to cancel an appointment at least 24 hours in advance may result in a $25.00 fee.
* Agree to participate in PCPCH when applicable.

_____ _____ _____ _____

Patient/Responsible Party Signature Date Witness/Receptionist Signature Date

Physicians' Medical Center, PC

254 NE Norton Lane. McMinnville OR 97128 (503)472-6161 / (503) 434-6290

NEW PATIENT HISTORY FORM

PLEASE RETURN THIS COMPLETED FORM PRIOR TO YOUR APPOINTMENT

(Nombre) (Fecha de nacimiento)
Name:_____ Date of Birth:_____

Date you are filling out this form (Fecha que lleno este formulario): _____

Physician/provider sending you to us (Médico/proveedor que lo envio a nosotros): Dr._____

Complaint/disease/reason for requesting this visit (Denuncia, enfermedad y razón para solicitar esta visita)

_____

_____

_____

MEDICATIONS: (please use back of form for additional meds)
MEDICAMENTOS: (por favor utilice la parte de atras para medicinas adicionales)

Prescription medications Medicamentos recetados	Dose Dosis	How often taken con qué frecuencia?

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, vitamins, laxatives, etc)
NO prescripción (medicamentos de venta libre, como aspirina, ibuprofeno, vitaminas, laxantes, etc)

Over the counter medications Los medicamentos	Dose Dosis	How often taken con qué frecuencia?

HERBAL PREPARATIONS / PREPARACIÓN

Herbal preparation preparación Herbal	Dose Dosis	How often taken con qué frecuencia?

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction
ALERGIAS O REACCIONES ADVERSAS DE DROGAS? Enliste drogas y tipo de reacción

Allergies or Drug Alergia or medicina	Reaction Reacción

PAST MEDICAL HISTORY (PASADO MÉDIC HISTORIA) :

Please check past medical history:

__High Blood Pressure/ *Hipertensión Arterial* (401.1)
__Heart Disease/ *Enfermedad Corazón* (414.0)
__High Cholesterol/ *Máximo Colesterol* (272.0)
__Asthma/ *Asma* (493.90)
__Diabetes Adult/ *Diabetes Adulto* 250.00)
__Diabetes Childhood/ *Diabetes Infancia* (250.01)
__Kidney Stones/ *Rinon Piedra* (592.0)
__Emphysema/ *Enfisema* (496.0)
__Depression/ *Depresión* (311.0)
__Heart arrhythmia/ *Arritmia del corazon* (427.9)
__Peptic Ulcer disease/ *Ulcera Peptica* (533.90)
__Low Thyroid / *Tiroides baja* (244.9)
__Allergic Rhinitis/ *Rinitis alergica* (285.9)
__History of stroke/ *Embolio* (434.91)
__Sleep Apnea/ *Apnea de Sueno* (780.57)
__Anemia / *Anemia* (285.9)

SURGICAL HISTORY: list any surgeries (operations), reason for the surgery, and date of surgery:
QUIRÚRGICO HISTORIA quirúrgica: lista cualquier cirugías (operaciones), en razón de la cirugía y la fecha de la cirugía:

Surgery/Operation ***Cirugía/ Operación***	**Date** ***Fecha***	**Physician**

FAMILY HISTORY / FAMILIA HISTORIA:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives
Coloque una "X" en los cuadros correspondientes para identificar enfermedades y condiciones todos en nuestros parientes de sangre

Illness/Condition *Enfermedad/Condiciones*	grand parent *abuelos* P= paternal M = maternal	father *padre*	mother *madre*	brother *hermano*	sister *hermana*	son *hijo*	daughter *hija*
Colon or rectal cancer *Colon o cáncer rectal*							
Breast Cancer *Cancer de pecho*							
Heart disease *Enfermedad Corazón*							
Diabetes							
High blood pressure/*presión alta*							
High cholesterol/*Alto cholesterol*							

Illness/Condition *Enfermedad/Condiciones*	grand parent *abuelos* P= paternal M = maternal	father *padre*	mother *madre*	brother *hermano*	sister *hermana*	son *hijo*	daughter *hija*
Alcohol/drug Alcohol/*droga*							
Depression/psychiatric illness *Depression/ enfermedad psiquiátrico*							
Genetic (inherited) disorder *Desorden genético (hereditaria)*							
Prostate cancer *Cáncer de prostata*							
Ovarian cancer *Cancer del ovario*							
Other *Otro*							

ADDITIONAL HISTORY: List any additional medical history:
HISTORIA adicional: Lista cualquier historia clínica adicional:

_____

_____

_____

SOCIAL HISTORY/ *HISTORIA SOCIAL*

Home situation/ *situación casa*
Single / *Soltero* _____ Married / *Casado* (how long/ *cuanto tiempo*) _____

Significant other / *Otra pareja* _____ Other / *Otro* _____

How many children / *Cuántos niños* _____ Are they healthy / *Son saludables* _____

Employment / Empleo:

Employed / *Empleado* ____ Unemployed / *Desempleado* _____ Retired / *Jubilado* ____

Disabled / *Discapacitado* _____ Other / *Otro* _____

Occupation / ocupación:_____
type of work or job/ tipo de trabajo o de empleo

Habits:

Tobacco ./ Tabaco:

Do you use any tobacco / *Utiliza cualquier tabaco*? No___ Yes/*Si* ____
If quit, how long ago / *Si ha dejado ase cuanto tiempo?* _____
If yes, how many packs per day / *En caso afirmativo, cuántos paquetes por día*? _____
Do you want to quit/ *Desea dejar*? _____

GENDER IDENTITY /*IDENTIDAD DE GÉNERO* _____

SEXUAL ORIENTATION/*ORIENTACIÓN SEXUAL*

Lesbian, gay or homosexual/*Lesbiana, Gay u Homosexual*	
Straight or heterosexual/*Heterosexual*	
Bisexual/*Bisexual*	
Something else, please describe/*Algo más, por favor Describa*	
Don't know/*No sé*	
Choose not to disclose/*Elige no divulgar*	
None/*Ninguna*	

RISK FACTORS FACTORES/ DE RIESGO FACTOR

Procedure/procedimiento	**Date/ *Fecha***	**Physician / *Médico***
Last Colonoscopy *Ultimo colonoscopia*		
Last Bone Density *Ultimo densidad del hueso*		
Last Pap Smear *Ultimo papanicolado*		
Last Mammogram *Ultimo mammograma*		
Last PSA/Prostate Exam *Ultimo exam de prostata*		

Do you use seatbelts/*Utilizas cinturones de seguridad* No_____ Yes/*Sí* _____

IMMUNIZATONS: if YES, give approximate year given and where you received the immunization.
***IMMUNIZATIONS**: en caso afirmativo, dar aproximado año dado y en la que recibió la inmunización*

Immunization	**No/Yes** **No/** *Si*	**Year/** ***Años***	**Where/ *Dónde***
Pneumococcal/N*eumococico*			
Hepatitis A/ Hepatitis A			
Hepatitis B/ Hepatitis B			
Tetanus/ Tétanos			

Are you up-to-date on your immunizations / esta al corriente en sus vacunas? _____

ACKNOWLEDGMENT AND CONSENT

I understand that **Physicians' Medical Center, P.C**. (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:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- 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
- 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.

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_____

PHYSICIANS' MEDICAL CENTER, P.C.

2435 NE Cumulus Avenue Suite A
MCMINNVILLE, OR 97128
TELEPHONE (503) 472-6161 FAX (503) 434-6290

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ALL SECTIONS OF THE AUTHORIZATION **MUST** BE COMPLETED OR THE AUTHORIZATION WILL NOT BE ACCEPTED.

I authorize:

_____
(Physicians' Medical Center and or Providers Name Authorized to Release the Information)

_____
(Address of person / entity)

_____
(City, State, Zip Code)

To use and disclose a copy of the specific health information described below regarding:

_____ _____ _____/_____/_____
(Name of patient) *(Date of Birth)* *(Social Security #)*

_____ _____
(Address of patient) *Patient's Telephone #*

_____
(City, State, Zip Code)

Consisting of: Dates of Health Care Information to Be Released: From (date)_____ **To (date)**_____

*(Check all that apply) * Please refer to Photocopy Charges Form*

_____Clinic notes
_____History and Physical examinations
_____Discharge summary
_____Laboratory Reports
_____Other_____

_____Consultation reports
_____Operative reports
_____ X-ray/Diagnostic images
_____ EKG, EEG

To: **PHYSICIANS' MEDICAL CENTER, P.C**
2435 CUMULUS AVE. SUITE A
MCMINNVILLE, OR 97128

Purpose of Request: _____Treatment/Consultation ____Transfer of Care ____Billing or Claims ____At the Request of the Patient

Other:_____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release:
I understand that if my medical or billing record contains information in reference to: drug and /or alcohol abuse, psychiatric care, sexually transmitted diseases, Hepatitis testing, genetic testing, and/or other sensitive information, I agree to its release**. ❑ Yes ❑ No Initials**____

I understand that if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and /or treatment, I agree to its release**. ❑ Yes ❑ No Initials** _____

Time Limit & Right to Revoke Authorization: This authorization is voluntary, and you may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services unless specified above under Purpose of Request. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to the **Privacy Officer** at 2435 NE Cumulus Ave Ste A, McMinnville, Oregon 97128 and state that you are revoking this authorization.

Re-disclosure: I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it.
Unless revoked this authorization will expire **180 days** or on the following date or event: the_____ day of _____,20_____

Signature_____ Date:_____
(Signature of Patient or Legally Authorized Representative)

Description of relationship to patient: _____ ☐ I would like the records mailed ☐ I will pick up the records

Office Use Only: Processed by_____ (Employee Name) Date_____
Mailed ❑ Faxed ❑ Other: _____

++

ALTERNATE CONTACT PERSON

PHYSICIANS' MEDICAL CENTER, P.C.

_____ _____ _____

Patients Full Name (*Please Print)* Date of Birth Telephone Number

☐ **Adult Consent *(Age I8 and older)***: I give my permission for Physicians' Medical Center, P.C. to discuss my medical care including Lab and x-ray results, on-going treatment and billing information with the following contact person(s) listed below:

☐ **Minor Child Consent (Under 18 years of age)** I give my permission for Physicians' Medical Center to discuss my child's (name listed above) medical care Including lab and x-ray, on-going treatment and billing information with the following contact person(s) listed below:

_____ _____ who can be reached at _____

Alternate Contact Person Name Relationship Telephone #

_____ _____ who can be reached at_____

Alternate Contact Person Name Relationship Telephone #

I also give permission for the alternate contact person listed above to pick-up the following paperwork on my behalf.

Billing Record ☐ Yes ☐ No Lab Results ☐ Yes ☐ No

X-Ray Reports ☐ Yes ☐ No Office Visits ☐ Yes ☐ No

Consultations ☐ ☐ No Other:_____

_____ _____ _____

Patient Signature (*Parent or Legal Guardian Signature if Patient is a Minor)* Relationship Date

Revised 9/20/19