

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

Dear Parents:

In order to be compliant with HIPAA regulations, we will need to enforce the following procedures:

- All new Pediatric Patients must be accompanied by biological parent/Foster Parent or ***legal guardians**.
- For **Foster Parent's** we must have a copy of the placement letter on file.
- An authorization form will have to be signed by the biological parent, **foster parent** or **legal guardian** (a court order will need to be on file in our office) if someone (for example, a step-parent, grandparent, or other family member, nanny, neighbor etc.) other than the parent, ***legal guardian** or **foster parent** is:
 1. Bringing the child in for a visit;
 2. Picking up forms, referrals, etc.
 3. Making appointments or calling for medical advice
 4. Receptionist will ask for photo identification when picking up forms or prescriptions
- An authorization form will be needed for us to:
 1. Mail or Fax forms to someone other than parent (example: camp, school, day care)
 2. Comply with a request for Medication to be given in school, camp or day care
 3. Transfer records to another provider outside of this clinic unless on a referral basis.
 4. Send your child's records to another person or business not mentioned above (example: Life Insurance Company or Attorney).
 5. Discuss your child's care with another person other than the parent, *legal guardian or another healthcare worker involved in the care of your child.

Legal Guardian: A court order showing *legal guardianship is required to be on file in our office

Disclaimer: *Under specific circumstances the law allows some children of certain ages the right to consent to treatment without parental consent.*

If you have questions regarding our Privacy Policies, please contact our Privacy Health Officer at 503-434-8238



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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.

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 Centers
Immunization Schedule Statement

Patient Name: _____ Birthdate: _____

Physician's Medical Center (PMC) follows the vaccination schedule set by the Center for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP). This schedule is supported by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

All providers at PMC support the CDC schedule and will continue to encourage fully vaccinating your child. If you decide otherwise, please schedule an appointment with your provider for discussion. This appointment will give you the opportunity to address questions or concerns you may have. If an alternative schedule was chosen we expect you will bring with you to each appointment. We will not choose preference of one vaccine over another and will recommend all vaccines at the appropriate time.

Once the schedule is reviewed by a provider at an appointment, it may be possible to get vaccines at nurse-only visits.

Appointments with a provider will be necessary if:

- There are any changes to the pre-reviewed schedule.
- Your child is not up to date on well child exams.
- There are questions or concerns that arise with vaccine record

Below are resources for immunizations:

- www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
 - You can use the schedule tools provided on this website to help create your catch up schedule.
- www.cdc.gov/vaccines/parents
- www.vaccineinformation.org
- www.aap.org
- www.aafp.org
- www.vaccine.chop.edu

Our goal at PMC is to provide your family with the best possible medical care. We believe that evidence-based medicine is the best way to provide quality care to our patients.

If you would like further information, please contact our office at (503) 472-6161.

I have read the above statement and understand Physician's Medical Center's immunization schedule statement:

(Parent/guardian)

(Relationship to patient)

(Date)

Pediatric New Patient Packet

Please fill out all questions if applicable, as appropriately and honestly as you can.

Child's Name:	Nickname:	Date of Birth:
Address:	City:	State:
Primary Phone:	Cell:	
Email for Portal Access:	Primary Language:	
Gender Identity:	Sexual Orientation:	

Household- Please list ALL people living in home; relative or non-relative.			
Name:	Date of Birth:	Relationship:	Occupation (if applicable)
If not listed above, please list patient's biological parents and siblings			

Birth History

Which hospital was patient born at: _____ How many weeks was child when born? _____
 Delivery: Vaginal ___ Cesarean ___ Complications with pregnancy? _____
 Birth Weight: _____ lbs _____ oz Vitamin K: Yes/No Hep B: Yes/No
 Any smoking while pregnant? _____ Alcohol or Drug use? _____
 Medications taken during pregnancy: _____
 Did baby have to be hospitalized for anything after birth? _____

General information for our records (if applicable)

Do you consider your child to be in good health? _____
 Does your child have any serious illness or medical condition? _____
 Has your child had serious injuries or accidents? _____
 Has your child had any surgeries? _____
 Been hospitalized overnight? _____
 Medications taken daily? _____
 Allergy to **ANY** medications? _____
 Environmental or food allergies? _____
 Dentist that child sees? _____
 Any other providers that the patient sees? _____
 Vaccines up to date? If no, please explain _____

Development (if applicable)

What school (or daycare) and grade in school: _____
 Any special help or resources need at school, ex: IEP or 504 plan? _____
 Any concerns about your child's physical development? _____
 Any concerns about your child's mental or emotional development? _____

Pediatric New Patient Packet

Please fill out all questions if applicable, as appropriately and honestly as you can.

Example:

Patient and Family History- For this please only include mother, father, and blood siblings.			
ADHD	X		Patient's Father

Patient and Family History- For this please only include mother, father, and blood siblings.

Problem	Yes	No	WHO?	Comments
ADHD				
Allergies/ Hayfever				
Anemia				
Arthritis				
Asthma				
Deafness				
Heart problems				
Vision problem				
Frequent ear infections				
Chickenpox				
Diabetes				
Epilepsy				
High blood pressure				
High cholesterol				
Liver or Kidney disease				
Mental illness/Depression				
Thyroid disease				
Alcohol/ Drug abuse				
Cancer(s)				
Autism				
Skin condition				
Frequent headaches				
Constipation/ Abdominal Pain				
Bed-wetting (after 5 years of age)				
Any other significant problems				

Home Environment- Please check all items that apply to your household.

- Well Water
- City Water
- Smoke detectors
- Carbon monoxide detectors
- Pets
- Do you have any transportation issues?
- Smokers in the home, or outside?
- Do you need help finding resources for your child or family?
- Do you need help understanding your child's medications?
- Do you need extra support with your child's diagnosis?
- Do you or your child need any extra help?

Print name of Patient/Parent/Guardian: _____

Signature of Patient/Parent/Guardian: _____ Date: _____

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

_____ Consultation reports

_____ History and Physical examinations

_____ Operative reports

_____ Discharge summary

_____ X-ray/Diagnostic images

_____ Laboratory Reports

_____ EKG, EEG

_____ Other _____

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: _____

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 have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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- or -

By: _____ (Patient representative)	Date: _____
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Description of representative's authority _____

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ALTERNATE CONTACT PERSON
PHYSICIANS' MEDICAL CENTER, P.C.

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

Adult Consent (Age 18 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