PMC Physicians' Medical Center, PC

2435 NE Cumulus Ave., Suite A, McMinnville, OR 97128Phone: 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

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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

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 (APP) 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

Patient Information:

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

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

_____ _____
(City, State, Zip Code) *(Patient's Email)*

I Authorize Information to be Released *From*:

_____
(Name of Provider or Facility who is releasing the information)

_____
(Address)

_____
(City, State, Zip Code)

_____ _____
(Phone) *(Fax)*

Information to be Released *To:*

PHYSICIANS' MEDICAL CENTER, P.C.

2435 NE CUMULUS AVE STE A

MCMINNVILLE, OR 97128

PH: 503-472-6161 Fax: 503-434-6290

Type of Information:

_____All Records _____Office Visit Notes _____Consult Reports
_____Hospital Reports _____Imaging Reports _____Laboratory Reports
_____Other_____

Dates to be Released: _____All _____Last 2 years Records from Date_____to_____

Method for Delivery: _____Fax _____Mail _____Email _____Pick Up

Purpose of Request: _____Treatment/Consultation _____Transfer of Care _____Billing or Claims _____At the Request of the Patient

Other:_____

Protected or Sensitive Information:
I understand that if my medical or billing record contains information in reference to the specific type of information below, laws of use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the space next to the type of information.

_____**HIV/AIDS** _____**Genetic Testing** _____**Mental Health Information** _____**Drug/Alcohol Treatment Information**
(*Initials*) *(Initials)* *(Initials)* *(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 in **180 days** or on the following date _____.

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

Description of relationship to patient: _____

Office Use Only: Processed by_____ (Employee Name) Date_____

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_____

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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 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