PLEASE USE BLUE OR BLACK INK

Name:_____ Date of Birth:_____

# Patient History

Your history is an important part of providing quality care. We collect this information to aid in making medically relevant decisions for your current and future care. Please fill out the forms to the best of your ability and give it to your provider or medical assistant.

## Patient Medical History

Please check, "Y" for yes or "N" for no, for each of the following condition you have had in the past

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | Y | N | Diabetes Mellitus | Y | N | Myocardial Infarction (Heart Attack) | Y | N |
| Anemia | Y | N | Emphysema/COPD | Y | N | Nerve / Muscle Disease | Y | N |
| Anxiety | Y | N | GERD | Y | N | Osteoporosis | Y | N |
| Arthritis/Joint Disorder | Y | N | Glaucoma | Y | N | Seizures | Y | N |
| Asthma | Y | N | Heart Failure | Y | N | Sickle Cell Anemia | Y | N |
| Blood Transfusion | Y | N | Heart Murmur | Y | N | Stomach Ulcers | Y | N |
| Cancer | Y | N | HIV/AIDS | Y | N | Stroke | Y | N |
| Cataracts | Y | N | Hypertension | Y | N | Substance Abuse | Y | N |
| Clotting Disorder | Y | N | Kidney Disease | Y | N | Thyroid Disease | Y | N |
| COPD | Y | N | Meningitis | Y | N | Tuberculosis | Y | N |
| Depression | Y | N | | | | | | |

| | |
|---|---|
| Please list any other conditions you have had here | |

## Patient Surgical History

Please check, "Y" for yes or "N" for no if you have ever had any of the following surgeries

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Appendectomy | Y | N | Cosmetic Surgery | Y | N | Prostate Surgery | Y | N |
| Brain Surgery | Y | N | Eye Surgery | Y | N | Small Intestine Surgery | Y | N |
| Breast Surgery | Y | N | Fracture Surgery | Y | N | Spine Surgery | Y | N |
| C-Section | Y | N | Hernia Repair | Y | N | Tubal Ligation | Y | N |
| CABG | Y | N | Hysterectomy | Y | N | Valve Replacement | Y | N |
| Cholecystectomy (Gallbladder) | Y | N | Joint Replacement | Y | N | Vasectomy | Y | N |
| Cosmetic Surgery | Y | N | | | | | | |

| | |
|---|---|
| Please list any other surgeries you have had here | |

Name: _____ Date of Birth: _____

# Patient Family History

*Family history helps us identify possible problems that may be avoided by screening. Please use a check for any conditions that apply to the family member indicated by the row. Place a check mark for every condition that you are aware of for each family member. Please try to be as accurate as possible.*

| Relationship | Name | Deceased? | Conditions: No Significant Past Medical History | Alcohol/drug addiction | Allergies | Arthritis | Asthma | Bleeding/Blood Disorder | Cancer | COPD | Depression | Diabetes | Gastrointestinal problems | Genetic Diseases / Birth Defects | genitourinary Problems | Headaches | Hearing Loss | Heart problems | High Cholesterol | Hypertension | Kidney Disease | Mental Illness | Musculoskeletal disorders | Nervous System Disorders | Obesity | Osteoporosis | Sickle cell anemia | Stroke | Thyroid Disease | Tuberculosis | Vision Problems |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sister | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brother | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Daughter | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Son | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mother Side Aunt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mother Side Uncle | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father Side Aunt | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father Side Uncle | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mother Side Grandma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mother Side Grandpa | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father Side Grandma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Father Side Grandpa | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Negative for Entire Family | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

## Home Environment

What type of Residence? (Please Check one) ☐ Single Family ☐ Multi-Family ☐ Trailer ☐ Temporary Was your residence built before 1978? ☐ Yes ☐ No

Are there tobacco users / smokers at home? ☐ Yes ☐ No

Is anyone a regular user of alcohol or drugs at home? ☐ Yes ☐ No

Are there guns / firearms in the home? ☐ Yes ☐ No

Is anyone being hit / hurt or touched in a bad way at home? ☐ Yes ☐ No

Do you have enough money for food? ☐ Yes ☐ No

Do you have enough money for utilities? ☐ Yes ☐ No

Is there anyone in the household with mental illness? ☐ Yes ☐ No

Do you have enough Money For housing? ☐ Yes ☐ No

Do you have transportation to get to your appointments? ☐ Yes ☐ No

If yes, are they being medically treated for the mental illness? ☐ Yes ☐ No

# La Pine Community Health Center

## NEW PATIENT INFORMATION DATA SHEET

Patient's Name: _____ Date_____
(LAST, FIRST, MIDDLE INITIAL)

Date of Birth: _____ Sex: M or F (Please Circle) Patient's SSN#:_____

Marital Status: [ ] Child [ ] Single [ ] Married - Spouses Name_____ [ ] Divorced [ ] Widowed

Home Phone: _____ OK to contact ___ Y ____ N Work Phone: _____ OK to contact ___Y ___N

Cell Phone: _____ OK to contact ___Y ____ N

Mailing Address: _____ OK to contact ___Y___N
(PO BOX or Street Address) (City) (State) (Zip Code)

Physical Address: _____
(Street Address) (City) (State) (Zip Code)

Email Address: _____ OK to contact ____Y____N

Patient's Employer: _____

Patient's Driver License Number: _____ State: _____

Emergency Contact Name _____ Phone #_____ Relationship_____

Additional Contact Name _____ Phone#_____ Relationship_____

***RESPONSIBLE PARTY INFORMATION***

Name: _____ Phone#:_____

Date of Birth: _____ Sex: M or F (Please Circle) SSN#:_____

Mailing Address: _____
(PO BOX or Street Address) (City) (State) (Zip Code)

Physical Address: _____
(Street Address) (City) (State) (Zip Code)

Relationship to Patient: _____

Responsible Party's Employer: _____

Responsible Party's Driver License Number:_____ State:_____

**Other Information**

How did you hear about us? (Please Circle One)

(TV) (Newspaper) (Yellow Pages) (Another Doctor)

(Another patient or friend or relative) (Internet) (Radio Station(_____) (Other):_____

**La Pine Community Health Center**

## CONSENT TO TREATMENT:

I agree to get medical treatment from La Pine Community Health Center staff as my health care providers see fit. I understand that services might be tests to see what's wrong, exams, and treatment. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at the La Pine Community Health Center. I may cancel this consent in writing.

## CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Your protected health information is made up of your health condition(s) and treatment at the La Pine Community Health Center which includes lab test results, medical history, treatment progress or any other related information. By signing this form, you agree that the La Pine Community Health Center may use and release protected health information about you. It can be used for treatment and payment. It can also be used for health care operations and in other ways allowed by law. Our notice of privacy practices gives information about how the La Pine Community Health Center and its staff may use and release protected health information about you.

## PCPCH PARTICIPATION AND ENROLLMENT

I understand that La Pine Community Health Center is recognized as a Tier 3 Patient Centered Primary Care Home (PCPCH), certified through the Oregon Health Authority. My signature on this form indicates that I have received and read the PCPCH program outline and I agree to partner with La Pine Community Health Center and its providers to participate in their Patient Centered Medical Home program. I have received information on Patient Centered Primary Care Homes and will fulfill my role as a medical home patient.

## NOTICE OF PRIVACY PRACTICES

I have received a copy of La Pine Community Health Center's Notice of Privacy Practices and have had a chance to ask questions about how my information may be used or disclosed.

By signing this form I am giving consent to treatment, agreeing to participate in PCPCH, and acknowledging that I have received a copy of La Pine Community Health Center's Notice of Privacy Practices.

_____ _____

Print Patient Name Date of Birth

_____ _____

Signature(Patient/Parent/Guardian) Date

# La Pine Community Health Center
## Disclosure of Protected Health Information (PHI)
**(HIPAA Form)**

Patient Name: _____ DOB: _____

La Pine Community Health Center values the privacy of its patients and is committed to operating its practice in a manner that promotes patient confidentiality while providing high quality patient care.

At times, La Pine Community Health Center has a need to reach you for reasons related to care (for example, to discuss lab results or medication).

☐ I give my permission to La Pine Community Health Center to give protected health information to the following people in person, on the phone, and/or by leaving a voice mail message: (for example: lab or x-ray results, test results, medication information)

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Name:_____ Relationship:_____ Phone #_____

Names appearing above- do not need to be added below

☐ I give my permission to leave messages **(without giving protected health information)** with the person answering the phone or on voicemail at the following numbers:

Location or name: _____ Phone #_____

Location or name: _____ Phone #_____

Location or name: _____ Phone #_____

Signature _____
**(Patient/Parent/Guardian Signature)**

Print Name_____

Date_____

# La Pine Community Health Center

## Information Required for Federal Support

Date: _____ Name: _____

Please tell us about yourself or, if you are accompanying a patient, the patient who is being seen today. ***As a Federally Qualified Health Center we are required to report the information requested on this survey.*** Your cooperation is greatly appreciated and your answers will be held in strictest confidence.

1. What is the patient's date of birth? (Month/day/year) _____/_____/_____
2. What is the patient's gender? **Female** ☐ **Male** ☐
3. What is the patient's race? (Please check one)
   **White** ☐ **American Indian** ☐ **Alaska Native** ☐ **Black or African American** ☐
   **Native Hawaiian** ☐ **Pacific Islander** ☐ **Asian** ☐ **More than one race** ☐
4. Is the patient Hispanic or Latino? **Yes** ☐ **No** ☐
5. Are you a United States Veteran? **Yes** ☐ **No** ☐
6. Would it be useful for the patient to communicate in a language other than English? **Yes** ☐ **No** ☐

   If so, what language:_____

7. How many members live in your **household**(please circle one) **1 2 3 4 5 6 7 8 9 10 Other_____**

   **Household income? Monthly $_____ or Annually $_____**
   **(Required for Mandatory Reporting for our Federal Grant)**

8. How will this visit be paid? (check the single largest payment source)

**Medicare** ☐ **Medicaid** ☐ **Private Insurance** ☐ **_____(please, specify) Self-Pay** ☐

**Breast and Cervical Cancer (BCC)** ☐

9. Has your housing changed dramatically in the past year? **Yes** ☐ **No** ☐
10. Are you living in a shelter or other transient housing? **Yes** ☐ **No** ☐
11. In the past 24 months have you or another wage earner in your immediate family:
    - Been hired to do farm work including the processing, preparation, or delivery of agricultural products? **Yes** ☐ **No** ☐
    - Earned ½ of your family income from farm work? **Yes** ☐ **No** ☐
12. In the past 24 months have you:
    - Moved from this area to another county or state in search of farm work? **Yes** ☐ No ☐ **(if yes, migrant)**

    OR

    - Lived in this area and only worked during the harvest season? **Yes** ☐ **No** ☐ **(if yes, seasonal)**

La Pine Community HEALTH CENTER

## Insurance Information

## PLEASE SIGN BELOW EVEN IF YOU DO NOT HAVE INSURANCE

**Patient's Name: _____**

**Insurance Company (Primary):**_____ID#_____Group#_____

Policyholder's Name: _____ DOB: _____ Sex: M F (circle one)

Relationship to Patient: _____SS Number: _____

**Insurance Company (Secondary):**_____ID #_____Group#_____

Policyholder's Name: _____DOB: _____ Sex: M F (circle one)

Relationship to Patient: _____SS Number: _____

### *Financial Agreement and Authorization for Treatment*

The Providers and Staff of La Pine Community Health Center have your healthcare as our first priority. After we provide healthcare services to you, we will bill your insurance for you. We understand that at times insurance billings can seem complicated, and we have billing staff available to help you with questions you may have.

We will bill all insurance companies, but we have no control over the dollar amount a non-participating company will pay for your services. Payment has been set by these companies without our input and as a result, you, the patient can possibly be left with an account balance higher than expected.

It is important that you check with your insurance before you have any medical services rendered so that you will be informed of what the possible financial outcome for that service will be. We can provide you with any information you may need to verify with your insurance company.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I understand that I may be billed for non-cancelled appointments. I accept full responsibility for payment thereof, and I hereby assign to La Pine Community Health Center any and all insurance benefits due me to the full extent of my financial obligation to said provider. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required.

It is agreed that payments will not be delayed or withheld because of any insurance coverage and all proceeds of insurance are assigned and/or payable to this office where applicable. (A copy of this assignment is as valid as the original.)

**Agreement:** I hereby authorize the release of pertinent medical records to my insurance carrier(s).

I have read and understand the above information on Date: _____.

Signature_____ Printed Name_____

**LAPINE COMMUNITY HEALTH CENTER'S FINANCIAL POLICY**

***PAYMENT FOR SERVICES:***

**We will bill participating insurance companies as a courtesy to you** and will assist with your benefits. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. Insurance is a contract between you and your insurance carrier. Payment for services provided to you is ultimately your responsibility.

Payment is required at the time services are rendered **unless other arrangements have been made in advance**. This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. There will be a 25% discount for private paying individuals at the time of service. La Pine Community Health Center accepts cash, personal check, VISA, and MasterCard. There is a $10.00 service charge for returned checks.

***PAST DUE ACCOUNTS:***

Patients with an outstanding balance of 60 days overdue must make arrangements for payment. We realize that people may have financial difficulty at times. Therefore, we have implemented a payment plan for those who cannot pay in full at the time of service.

On accounts that have made payment arrangements, payment is due by the date agreed upon. Patient balances greater than 90 days old or those failing to honor agreed upon payment terms may be turned over to our collection agency. Any patient turned over to collections may be discharged from our practice.

***REFUNDS:***

Overpayments will be refunded upon written request to the responsible party within 30 days.

***CANCELLATIONS/MISSED APPOINTMENTS*:**

If you are unable to keep your appointment, please call us as soon as possible; appointments cancelled less than 24 hours are considered a NO SHOW. We realize emergencies come up and your plans may change. Giving us as much time as possible (at least 24 hours) helps us to better serve you and our other patients. In the event that you do not provide an appropriate notice, you may be charged $50.00 for the missed appointment. If you fail to keep your appointments with us for a total of 3 times, you may be discharged from the practice.

***MEDICAL RECORDS REQUEST:***

A written request must be signed by the patient or parent/legal representative in order to receive a copy of medical records. By law La Pine Community Health Center has 30 days to issue copies of medical records. I understand that I may be charged a fee of $25.00 plus $0.25 per page over 10 pages. This fee is waived for copies provided to a healthcare provider for continuing medical care. Medical records provided to attorneys or other professionals will be charged a flat rate of $25.00 plus $0.25 per page over 10 pages. Worker's Compensation or Motor Vehicle accounts will be charged $10.00 for the first page and $0.50 for every page thereafter.

***ASSISTANCE or QUESTIONS:***

If you need assistance or have questions regarding billing issues or the Financial Policy, please contact the billing office between:
8:00 a.m. and 4:30 p.m.
Monday through Friday at 541-536-3435

I have read and understand La Pine Community Health Center's Financial Policy. I agree to assign insurance benefits to La Pine Community Health Center whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections, including attorney fees.

_____ _____

Signature of patient/legal representative Date

_____

Printed Name