Oregon Psychiatric Partners, L.L.P.
&
Franc Strgar, MD, P.C.

PATIENT DEMOGRAPHICS **TODAYS DATE** _____

PATIENT NAME: _____ PREFERRED NAME: _____
FIRST M.I. LAST

DATE OF BIRTH: _____ AGE: _____ SEX: MALE ☐ FEMALE ☐ SSN# _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

MAILING ADDRESS (If Different From Above): _____ CITY: _____ STATE: _____ ZIPCODE: _____

PREFERRED PHONE #_____ CELL HOME WORK // **OK TO LEAVE MESSAGE** ☐ YES ☐ NO EMAIL ADDRESS: _____

APPOINTMENT REMINDER METHOD (Please Choose All That Apply): EMAIL ☐ TEXT ☐ TELEPHONE/VOICEMAIL ☐
I do not wish to receive appointment reminder notifications ☐

EMERGENCY CONTACT: _____ **PHONE**: _____ **PRIMARY CARE PROVIDER**: _____ **PHONE:** _____

PREFERRED PHARMACY (Name and Location): _____ **PHONE**: _____

PRIMARY INSURANCE: ARE YOU ELIGIBILE FOR MEDICARE? ☐ YES ☐ NO

PLAN NAME: _____ I.D. #: _____ GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDERS DATE OF BIRTH: _____
RELATIONSHIP TO POLICY HOLDER: Self_____ Parent _____ Spouse / Partner _____

SECONDARY INSURANCE:

PLAN NAME: _____ I.D. #: _____ GROUP NUMBER: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S DATE OF BIRTH: _____
RELATIONSHIP TO POLICY HOLDER: Self_____ Parent _____ Spouse / Partner _____

PERSON RESPONSIBLE FOR BILL (ONLY COMPLETE IF DIFFERENT FROM PATIENT):

RESPONSIBLE PARTY NAME: _____ DATE OF BIRTH: _____ PHONE #:: _____
First Last

ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

RELATIONSHIP TO PATIENT: Parent _____ Spouse / Partner _____ Other (please specify): _____

OPTIONAL INFORMATION

PREFERRED LANGUAGE: ☐ ENGLISH ☐ OTHER: (please list): _____ RACE: _____ ETHNICITY: _____ NON HISPANIC _____
HOW DID YOU HEAR ABOUT US? WEBSITE FRIEND/FAMILY PROVIDER REFERRAL (Provider Name): _____ OTHER: _____

By signing below I agree to receive appointment reminders in the method I have selected above. I understand I can revoke my selection at any time by submitting a written or verbal request to the office.

Patient or Legal Guardian Signature X _____ Date: _____

Oregon Psychiatric Partners, L.L.P.

3203 Willamette Street, Eugene OR 97405
1831 NW Kings Blvd, Corvallis OR 97330
Phone: 541-726-9912 Fax: 541-744-4443

CONSENT FOR TREATMENT AND BILLING

PATIENT NAME: _____ DATE OF BIRTH: _____

CONSENT FOR TREATMENT:
In mutual agreement with the provider, the undersigned hereby consents to all necessary treatments and/or diagnostic procedures within the scope of the practice of psychiatry/behavioral health services. I understand that my treatment and records are confidential as outlined by State and Federal Law. This consent also includes treatment (telephone or in person services) provided by any on-call provider.

X _____ _____

Patient Signature/ Legal Guardian Signature Date

CONSENT FOR TELEMEDICINE SERVICES:
I understand telemedicine services may be available to me. Upon program acceptance and in mutual agreement with the provider, the undersigned hereby consents to all necessary treatments and/or diagnostic procedures within the scope of the practice of psychiatry/behavioral health services via videoconferencing. I consent to using live video conferencing services provided by Oregon Psychiatric Partners Telemedicine Program. I understand that these services may involve the communication of my health information, both orally and visually, to the provider. Specifically, I understand that videoconferencing services include, but are not limited to, consultation, treatment, and transfer of health data using interactive audio, video, or data communications. I also understand that no data or health information will be recorded, stored, or archived from use of these live videoconferencing services.

I further understand the following with respect to use of Oregon Psychiatric Partners telemedicine services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment; nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my health information may also apply to these services as such, I understand that the information disclosed by me during the videoconference session is generally confidential. However there are both mandatory and permissive exceptions to confidentiality.
3. There are risks and consequences from use of these services, including, but not limited to, the possibility, despite reasonable efforts on the part of Oregon Psychiatric Partners, that: the transmission of my health information could be disrupted or distorted by technical failures; and/or transmission of my health information could be intercepted or accessed by unauthorized persons.
4. I have a right to access my health information and copies of health records in accordance with HIPAA privacy rules and applicable state law.
5. I understand videoconference sessions are billable in the same manner as my face to face sessions and that I am financially responsible for all fees regardless of insurance coverage. I further understand that all fees are to be paid at the time of service and I will call the office to make my payment prior to each video session.

I have read and understand the information provided above. I have discussed it with representatives from Oregon Psychiatric Partners, and all of my questions have been answered to my satisfaction.

X _____ _____

Patient Signature/ Legal Guardian Signature Date

NOTICE TO OUR PATIENTS WITH INSURANCE:
Your insurance is NOT a guarantee of payment. All fees and expenses incurred by the patient in this office are solely the responsibility of the patient (or parent, if patient is a minor). As a service to you, we will complete and submit your insurance claim. Regardless of any insurance claims, full payment is due in 60 days.

ASSIGNMENT OF INSURANCE BENEFITS:
I authorize the above providers to furnish my third party payer all relevant information which may be requested regarding my claim, including activities involved in determining eligibility, diagnosis, review of health care services for medical necessity, precertification and preauthorization, thus releasing any of the above providers from any liability for furnishing such information. I assign all payments to which I am entitled for expenses related to the services performed, but not to exceed my indebtedness to the above providers. It is understood that any money received from the insurance company over and above my indebtedness will be refunded when my bill is paid in full. My financial responsibility may be different from that stated on my insurance card because of psychiatric specialty fees and may not be known until after the insurance has paid. I understand that I may be billed for lengthy telephone consultations and reports, which may not be reimbursable by insurance. I understand that I am financially responsible for all fees regardless of insurance coverage and that it is customary to pay for services when rendered unless other arrangements have been made in advance.

By signing below I acknowledge I have read and understand the office policy statement and understand my financial responsibility.

X _____ _____

Signature of Person Financially Responsible for Payment Date

Oregon Psychiatric Partners, L.L.P
&
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3203 Willamette St. Eugene, OR. 97405
1831 NW Kings Blvd, Corvallis OR 97330
Phone: 541-726-9912 Fax: 541-744-4443

Name: **DOB:** **Date:**

Are you Allergic to any Medications? ☐ YES ☐ NO *If yes, please list medications below

Medication	Reaction

What Prescription Medications you are **Currently** taking: attach a current med list

Name of Medication	Amount/Dose	Name of Prescribing Doctor

Psychiatric Medications Tried & Failed	Amount/Dose

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FAMILY/FRIEND RELEASE OF INFORMATION FORM

I, _____ _____
(print patient name) (patient date of birth)

hereby authorize the providers and staff of Oregon Psychiatric Partners LLP and Franc Strgar MD PC to inform and/or involve the following family members and friends in my care and treatment planning. I understand that the providers and staff may verbally share information with the family and/or friend(s) listed below about my care plan, appointments, or account status. I understand that this release will also allow persons I have listed below to share information with the providers and staff regarding my condition.

Family and friends:

1. _____ _____ _____
Relation Address/Street Phone/Home

_____
City/State/Zip Phone/Work

2. _____ _____ _____
Relation Address/Street Phone/Home

_____
City/State/Zip Phone/Work

3. _____ _____ _____
Relation Address/Street Phone/Home

_____
City/State/Zip Phone/Work

4. _____ _____ _____
Relation Address/Street Phone/Home

_____
City/State/Zip Phone/Work

This authorization will remain in effect for the duration of my treatment or until cancelled in writing by the patient.

I understand I can cancel this release at any time, but the cancellation will not affect any information that was already released before the cancellation.

By signing below I understand that information specific to drug and alcohol treatment, psychiatric treatment, AIDS/HIV, and genetic test information can be released with this consent.

I understand information discussed may be re-disclosed by the receiving person and may no longer be covered under federal privacy laws.

I understand what this agreement means and I am satisfied with any explanations I may have requested and received.

_____ _____
Patient Signature Date

_____ _____
Person authorized to sign Relationship Date

Providers of:
Oregon Psychiatric Partners, L.L.P. & Franc Strgar, MD, P.C
3203 Willamette St. ~ Eugene, OR 97405
1831 NW Kings Blvd, Corvallis OR 97330
Phone 541-726-9912 ~ Fax 541-744-4443

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

Other Names Used: _____

For the purpose(s) of continuity of care, diagnosis, evaluation and treatment planning, I authorize my provider(s) at **OREGON PSYCHIATRIC PARTNERS, LLP, & FRANC STRGAR MD, PC** to release the following confidential information about me to the physician or organization listed below.

_____
(Name of Physician or Organization)

_____
(Address) (Telephone) (Fax)

By placing my initials here _____ I authorize the physician or organization listed above to release my medical record and information to my provider(s) at OREGON PSYCHIATRIC PARTNERS, LLP & FRANC STRGAR MD, PC.

I understand my record may include medical, mental health, and drug/alcohol diagnostic evaluations, treatment history, progress notes, summaries, medication history, laboratory test and reports, and hospital and immunization records.

I understand the following information can only be disclosed if I *initial below.* I further understand that federal and/or state laws prohibit the re-disclosure of mental health, drug and alcohol, and HIV/AIDS diagnoses and treatment information, and specific authorization is required for the release of such information.

_____ Mental Health records which may including drug/alcohol diagnoses and treatment or referral information
_____ HIV/AIDS related information and/or records
_____ Genetic Testing information and/or records

Please indicate purpose for this release:

☐ **Ongoing:** To Allow ongoing communication between my care providers.

☐ **Single Event**: This is a one-time request to transfer all my records from Oregon Psychiatric Partners to the entity listed above.

If you are requesting a specific record to be released, please specify the document below:

_____

By signing below:

I authorize the release of the medical records noted above and I understand the person or organization receiving these records could re-disclose the records and they may not be covered under federal privacy laws.

I understand this release will remain in effect until:

☐ My care is terminated by my provider or myself.

☐ The designated time period of _____ days has lapsed.

☐ The single event has been fulfilled, which I understand may take 30 days from the date of the request.

I understand that information about my care is confidential and protected by state and federal law and I may cancel this authorization at any time. To cancel the authorization, I must provide a written request to cancel. The request to cancel this consent will not affect information that was released prior to the date of my cancellation request.

I agree I have read the entire release and I understand this authorization is voluntary and I may refuse to sign the authorization. I understand if I do not sign this authorization it will not affect my ability to obtain treatment or payment or my eligibility for benefits.

_____ _____ _____
Date Signature of Patient or Guardian Type of Guardianship

OREGON PSYCHIATRIC PARTNERS, LLP
&
Franc Strgar, MD PC

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient DOB:** _______________________

By signing below I acknowledge that I have received, or have been offered, a copy of the Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)
☐ Parent or guardian of unemancipated minor
☐ Court appointed guardian
☐ Executor or administrator of decedent's estate
☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

☐ Patient/representative refused to sign
☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
☐ Communication barriers prohibited obtaining acknowledgement (Explain)
____
____
____
____
____

☐ Other (Specify)
____
____
____
____
____

Oregon Psychiatric Partners, L.L.P.
&
Franc Strgar MD, P.C.

OFFICE POLICY STATEMENT

PHONE HOURS:

The office staff is available by telephone Monday thru Friday from 9:00am to 4:30pm. The staff is not available by phone during the lunch hour from 11:30am to 1:00pm.

DAYS OF OPERATION:

The Corvallis office is open Tuesday through Friday

The Eugene office is open Monday through Friday.

Providers do have varying schedules and may not be available each day.

All offices are closed on the first Friday of each month and most national holidays. Other closures may be necessary from time to time. Please check our website calendar for updates.

Our answering service operator is available to assist you at all times. In the event you have an urgent need during business hours, evenings or weekends, you may be referred to the on-call provider if your regular provider is not available. In the event of any after-hours emergency, the answering service will contact your provider or the on-call provider. If you are unable to wait for a return call, please go to your local emergency room.

APPOINTMENT and EMERGENCIES:

It is your responsibility to attend scheduled appointments. **If you cannot keep your appointment, please call at least 24 hours in advance to cancel or reschedule.** Any request to cancel or reschedule may be left on our voicemail after hours and on weekends. Giving advance notice may secure continued care.

Frequent missed appointment and last-minute cancellations may result in termination of your care in this office. If you miss two (2) appointments, or cancel up to two (2) appointments in less than 24 hours, your services may be terminated at this practice.

New patients; If you need to cancel or reschedule your initial visit, please contact the office at least 24 hours in advance. **If you Late Cancel or No Show for the appointment your chart will be closed and you will Not be eligible to reschedule within the practice.**

MEDICATION REFILLS:

If you need a medication refill, **call your pharmacy even if the bottle says no refills:**

Request refills at least 4 days before you need to pick up your medication. This will allow time for the pharmacy to process the request, contact your provider, and allow time for your provider to respond.

REFILLS WILL NOT BE PROCESSED AFTER REGULAR BUSINESS HOURS OR ON WEEKENDS.

MEDICATION CHANGES:

All medication changes will require a visit with your provider.

PSYCHIATRIC FEES and BILLING:

Please contact the office any time you have changes in your insurance or billing information. **You are expected to pay your "Copay" "Deductible" "Coinsurance" or an estimate of the amount we expect you will owe, and any outstanding balance at the time of your appointment. Private pay accounts are required to make payment in full at the time of each appointment.** Please contact the billing office if you have questions about fees and payments.

REPORTS, DOCUMENTS and REQUESTS:

If you are applying for disability, involved in a legal dispute, or require written reports for a third-party insurance or any other entity, please be aware the **completion of forms and documents is not a requirement of your provider.** Providers may refuse the request. Any document that is completed at your request, the request of your attorney, or third-party entities, will be billed to you. **You will be responsible for the fee** and you may be required to pay the fee prior to completion. If your provider agrees to complete such a request, the provider will make every effort to do so within 14 days of receipt. In some cases, completion of documents or preparation of medical records may take up to 30 days.

TREATMENT PLAN:

You have the right to participate in forming your treatment plan and ask why any form of treatment is recommended. You may at any time refuse treatment or request a change in treatment approach. Please discuss this further with your provider.

PROVIDER RESPONSIBILITIES DISCLAIMER:

It is your responsibility to notify the office if your insurance changes or if your insurance requires pre-authorization. It is your responsibility to be aware of your insurance company's preauthorization requirements and if your policy has plan limitations. Authorization for sessions does not guarantee available benefits. If benefits exhaust, preexisting conditions apply, or current insurance is not provided in a timely manner you will be personally responsible for the bill. Payment is due within 30 days of mailing or billing statement notice.

Oregon Psychiatric Partners, L.L.P.
&
Franc Strgar MD, P.C.

PATIENT RESPONSIBILITIES:

We consider you a partner in your health care. When you are well informed, participate in treatment decisions and communicate openly with your doctor and other health professionals, you help make your care as effective as possible. We encourage respect for the personal preferences and values of each individual.

While you are a patient of Oregon Psychiatric Partners and/or Dr. Franc Strgar, MD, P.C. your rights include the following:

- You will have the right to considerate and respectful care.
- You will have the right to be well informed about your illness, possible treatments and likely outcome and to discuss this information with your provider. You have the right to know the names and roles of the people treating you.
- You have the right to consent to or refuse a treatment as permitted by law. If you refuse a recommended treatment, you will receive other needed and available care.
- You have the right to privacy. Our group, your provider, and others caring for you will protect your privacy as much as possible.
- You have the right to expect a timely response to questions regarding medication and side effects.
- You have the right to expect that treatment records are kept confidential unless you have given permission to release information or we are reporting as required or permitted by law. When we release records to others, such as insurers, it emphasized that the records are confidential.
- You have the right to expect that we will give you necessary health services to the best of our ability. Treatment, referral or transfer may be recommended. If transfer is recommended or requested, you will be informed of risks, benefits and alternatives.
- You are responsible for providing information about your health, including past illnesses, hospital stays, and use of medicine.
- You are responsible for asking questions when you do not understand information or instructions. If you believe you can't follow through with your treatment, you are responsible for being considerate of the needs of other patients and staff.
- You are responsible for providing information for insurance and for working with us to arrange payment, when needed.
- Your health depends not just on the care you receive from the provider, but in the long term on the decisions you make in your daily life. You are responsible for recognizing the effect of lifestyle on your personal health.

BILLING RIGHTS AND RESPONSIBILITIES
If you have questions regarding this notice,
please contact the OPP Billing Office at 541-726-9912, or Dr. Strgars Billing Office At 541-497-8009

INSURANCE AND PREAUTHORIZATION:

Insurance companies may require authorization for certain services. Authorization does not guarantee payment. It is your responsibility to verify whether or not our providers are eligible for insurance reimbursement or if there are restrictions to your policy for specific providers and services. It is your responsibility to notify the office of your insurance requires preauthorization or if you have changes in your insurance plan or coverage. In many cases, you will be required to initiate the request for a referral to our office. It is also your responsibility to monitor the actual benefits you have used. If benefits terminate, authorized sessions have been used, or deductibles, co-pays or co-insurance are a requirement of your plan, you are personally responsible for the billed services.

NOTIFY US OF ERRORS OR BILLING QUESTIONS:

If you think your bill is incorrect or if you need more information about a transaction on your bill, write to us at the address on your bill as soon as possible, but no later than 30 days after you receive the first statement on which the problem appeared. You can telephone us, but doing so will not preserve your rights. **In your letter, identify the following information:**

- Your name and account number (located on your statement)
- The name of the provider (located on your statement)
- Explain why you believe there is an error.

YOUR RIGHTS AND RESPONSIBLITIES AFTER WRITTEN NOTIFICATION:

We must acknowledge your letter within 30 days unless we have corrected the error before then. Within 90 days, we must either correct the error or explain why we believe the bill is correct. You will continue to receive billing statements until the issue is resolved. If we find that we made a mistake on your bill, we will send you a statement of the corrected amount you owe and the day your payment is due.

PAYMENT OF ACCOUNT:

Providers of Oregon Psychiatric Partners and Dr. Strgar MD, P.C. reserve the right to require prepayment of all services. Your financial responsibility may be different from that stated on your insurance card because of psychiatry specialty fees which may not be known until after the insurance has been billed. All accounts not paid within 30 days may be considered past due unless payment arrangements are made. A $25 fee will be charged to the patient for any check returned to us for insufficient funds (NSF).