Family Tree Medical Clinic

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Gender: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Would you like to be registered for Portal Access? **Y** **N**

Mailing Address: _____ City: _____ Zip: _____

Race/Ethnicity: White / Hispanic / American Indian or Alaska Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / Middle Eastern or North African / Don't Know / Don't want to answer

Primary Insurance: _____ ID #_____ Group # _____

Secondary Insurance: _____ ID #_____ Group # _____

BECAUSE THERE ARE IMMEDIATE EXPENSES TO PROVIDE A SERVICE TO OUR PATIENTS, WE EXPECT YOU TO CONTRIBUTE YOUR PORTION WHEN APPLICABLE. THE FOLLOWING FORMS OF PAYMENT ARE REQUIRED.

INSURANCE: We will bill your insurance as a courtesy.

CO-PAYMENTS: Due each office visit prior to seeing the provider. _____ Initial
CO-INSURANCE: Applicable percentage amount will be collected at the time of service. Our office staff will do their best to collect the exact amount owed; however, there may be a small credit or an additional amount due after insurance processing. _____ Initial
DEDUCTIBLES: If you have a high deductible plan, we may ask you to pay towards your visit prior to seeing the provider. _____ Initial
SELF PAY: Due in full at the time of service.
PATIENT RESPONSIBILITY: Patient balance responsibility beyond insurance, are due within 30 days of the date of service.
NON-COVERED SERVICES: Non-covered services are the responsibility of the patient/guardian. Non-covered services vary from each insurance company. These may include, but are not limited to, health physicals, laboratory tests, procedures, and injections.
LATE CHARGE: We reserve the right to impose, and you agree to pay, a late charge of 1.5 percent per month for any balance that remains outstanding 90 days after the date of service. _____ Initial
APPOINTMENT CANCELLATION: A 24-hour notice of appointment cancellation is required otherwise a $25.00 fee will be charged and your account marked as "no show". We reserve the right to discharge entire families with 3 "no shows" per family. _____ Initial

I have read the above Office Payment Policy and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand there is no interest or finance charge on current accounts. However, I am also aware that **delinquent accounts beyond 90 days are subject to other collection means at my own expense and no further appointments will be scheduled until my account is paid in full** unless prior arrangements have been made. I understand I may request a payment plan if necessary to keep my account in good standings.

I have read, understand, and agree to the above Office Payment Policy in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

_____ _____
Signature Date

_____ _____
Printed Name Patient Name (if different)

Family Tree Medical Clinic reserves the right to revise this agreement at any time with or without your consent.
Las Revised: 12/31/2024

Family Tree Medical Clinic

2508 NW Medical Park Drive, Roseburg, OR 97471
Phone: (541) 673-5225 Fax: (541) 229-4777
Dr. Sarah Agsten, DO and Dr. Heidi Beery, MD

Protected Health Information Disclosure Authorization and Consent

I, _____ (*name of patient*) _____ (*date of birth*), authorize Sarah L. Agsten, D.O. LLC, DBA Family Tree Medical Clinic to use and disclose my medical information described below to the following person(s):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check this box if you do not wish to authorize any contacts ☐

The health information to be used and disclosed includes the information specifically authorized below as well as all other information in my health records relevant to scheduling/discussing appointments or referrals; disclosing lab and/or imaging results.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the 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 applicable space next to the type of information.

____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.
____ By initialing here, I specifically consent to the disclosure of my mental health information.
____ By initialing here, I specifically consent to the disclosure of my genetic testing information.
____ By initialing here, I specifically consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date:_____
(signature of patient or patient's personal representative)

Authority: _____
(if you are signing as personal representative, please add a description of your authority to act for the patient)

Unless revoked in writing, this Authorization expires one year from the date above unless requested otherwise by your initials below in the appropriate section:

❒ 5 Years ( ) ❒ Never ( ) ❒ Other Date: _____ ( )

Please note:
You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

FAMILY TREE MEDICAL CLINIC

ACKNOWLEDGEMENT & CONSENT

I understand that Family Tree Medical Clinic, 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 works, 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 and other 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-effected 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 the 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.

We participate in local and national health information exchanges that permits health care providers to electronically exchange health information. Your health information may be shared with other providers and organizations when necessary and as appropriate for our and their treatment, payment, and health care operations purposes.

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.

Sign: _____ Date: _____

Patient's printed name: _____ Authority:_____

FAMILY TREE MEDICAL CLINIC

Sarah Agsten, DO
Heidi Beery, MD

NEW PATIENT HEALTH HISTORY

Full Name:	Birthdate:	Age:	Today's Date:

Occupation: ❑Retired	Marital Status: ❑ S ❑ M ❑ D ❑ W	Preferred Pharmacy:
Primary Phone #:	Special Interests:	

LIST PRESENT MEDICATION ❑ No Medications

Medication Name	Strength	Frequency	Medication Name	Strength	Frequency

ALLERGIES ❑ No Know Allergies

✓	List	Reaction	✓	List	Reaction
	Penicillin				
	Sulfa				
	Aspirin / NSAIDS				
	Foods				

Do you have any specific concerns you would like to discuss with the provider at your first visit?

PAST MEDICAL HISTORY (CHECK IF YOU HAVE HAD ANY OF THESE)

❑ Anemia ❑ Anxiety ❑ Arthritis ❑ Asthma ❑ Cancer ❑ COPD ❑ Diabetes ❑ Depression

❑ Diverticulosis ❑ Fibromyalgia ❑ Gout ❑ Heart Attack ❑ Hepatitis ❑ High Blood Pressure ❑ High Cholesterol

❑ Kidney Disease ❑ Liver Disease ❑ Migraines ❑ Seizures/Epilepsy ❑ Sleep Disorders ❑ Stroke

❑ Thyroid Disorders ❑ Urinary Disorders ❑ Other (Please list below)

FAMILY HEALTH HISTORY- Please list significant health problems in your immediate family. (List current age or age at death) ❑ Family History Unknown

Relation:	Problem(s)	Living?	Age

SURGICAL/PROCEDURE HISTORY ❑ No Surgical History

✓	Procedure	Date			
	Appendectomy			Back or Neck	
	Gall Bladder Removal			Joint Repair/Replacement	
	Tonsillectomy			Hernia Repair	
	Hysterectomy		✓	**Other Procedures: (List Below)**	**Date**
	Colonoscopy				
	Endoscopy				

Women's Health History		
Date of last period		
Number of Pregnancies		
Number of Live Births		
Number of Miscarriages		
Number of Abortions		
Currently Sexually Active?	YES	NO
Using Birth Control?	YES	NO
If yes, What kind?		
Year of last pap		
Year of last Mammogram		
Year of last DEXA Scan		

Social History	
Do you smoke?	Date Quit:
❑ Never ❑ Yes _____# packs/day ❑ Vape ❑ Former	
Do you Chew Tobacco?	Date Quit:
❑ Never ❑ Yes _____# cans/day ❑ Former	
Do you Consume Alcohol?	
❑ No ❑ Socially ❑ Minimally ❑ Moderately ❑ Heavily	
Drug Use?	
❑ Never ❑ Historically ❑ Daily ❑ Weekly ❑ Monthly ❑ > Monthly	

Additional Information:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Please complete this form in its entirety)

I, _____, Date of Birth: _____/_____/_____ **AUTHORIZES:**
(Print patient name)

Name of Facility/Doctor: _____
Address/City/Zip: _____
Phone Number: ( ) _____ Fax Number: ( ) _____

TO USE AND DISCLOSE A COPY OF THE HEALTH INFORMATION DESCRIBED BELOW REGARDING ME TO:

Name of Facility/Doctor: **FAMILY TREE MEDICAL CLINIC- Dr Agsten and Dr Beery**
Address/City/Zip: **2508 NW Medical Park Drive; Roseburg, Oregon 97471**
Phone Number: (**541**) **673-5225** Fax Number: (**541**) **229-4777**

Please indicate the last time you were seen at the requested office in order to better locate your records:
❒ Present to 2 years ❒ 3-5 years ❒ 6-10 years ❒ Over 10 years

PURPOSE OF RELEASE: ❒ Medical Care ☒ Transfer of Care ❒ Legal ❒ Other: _____

I CONSENT TO THE RELEASE OF: ☒ All Records (limited to chart notes from the last 3 years)
☒ Lab Reports (From the last 3 years) ☒ Imaging Reports (From the last 5 years) ☒ Diagnostic Reports (ALL)
☒ Colonoscopy reports and pathology reports (ALL)

THE HEALTH INFORMATION TO BE USED AND DISCLOSED INCLUDES THE INFORMATION SPECIFICALLY AUTHORIZED BELOW AS WELL AS ALL OTHER INFORMATION IN MY HEALTH RECORDS RELEVANT TO THE ABOVE-DESCRIBED PURPOSE.

____ By initialing here, I specifically consent to the disclosure of my HIV/AIDS information.

____ By initialing here, I specifically consent to the disclosure of my mental health information.

____ By initialing here, I specifically consent to the disclosure of my genetic testing information.

____ By initialing here, I specifically consent to the disclosure of my drug and alcohol diagnosis, treatment, or referral information, which requires under federal law a description of how much and what kind of information is to be disclosed.

I HAVE REVIEWED AND I UNDERSTAND THIS AUTHORIZATION. I ALSO UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND NO LONGER BE PROTECTED UNDER FEDERAL LAW. UNLESS REVOKED EARLIER, THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL MY DEATH.

_____ Dated _____, 20_____
(Signature of patient or legal guardian)

_____
(Print guardian name)

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this Authorization; and
4. We must provide you with a copy of the signed Authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.