Tualatin Internal Medicine, LLC

PATIENT INFO

First Name _____ Last Name_____ MI___

Preferred Name_____Date of Birth_____ Sex_____

Address_____

City _____ State_____Zip _____

CONTACT

Home_____ Cell_____ Work_____

May we leave a detailed message? Yes___ No___ If Yes, please circle preferred number.

May we text you for appointment reminders and messages? Yes___ No___

Preferred Language _____

Email address _____

EMPLOYMENT

Employer_____ Occupation_____

EMERGENCY CONTACT

Name_____ Phone number_____

Relationship to patient _____

FINANCIAL

Insurance Co_____ID_____ Group#_____

Subscriber (if different from patient) _____ DOB_____

Relationship to patient _____

PREFERRED PHARMACY

Pharmacy Name_____location_____

SIGNATURE_____**DATE**_____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Tualatin Internal Medicine, LLC to serve the health care needs for you and your family. We are pleased to participate in your health care and look forward to establishing a lasting relationship as your health care provider. As part of this relationship, we have outlined our expectations for your financial responsibility in our Patient Financial Responsibility Policy. Please read this document thoroughly.

Address change

- It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information. We mail out lab results, pathology and appointment information in addition to billing statements.

Co-payments, Deductibles and Co-Insurance

- Co-payments are collected at the time of check-in
- Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. We accept cash, check and most major credit cards

Billing

- If you owe additional money after your visit, you can expect to receive a statement. Statements are mailed out on a monthly basis. Payment is expected within 10 days of receipt of your statement.

Failure to Pay

- Patients who ignore collection notices and fail to pay their balance risk negative credit ratings and possible dismissal from the practice.
- Past due accounts may hinder your ability to have appointments scheduled.
- Should your account balance become uncollectible or if you file bankruptcy, we will continue to see you on an emergency basis only for 30 days, giving you time to find a new source of medical care.

Fees

- Returned checks are subject to a $25 fee and your account will be place on a “cash-only” basis. We will accept payments only by cash or credit card until the balance is cleared.
- Failure to give 24 hour cancellation notice or failure to keep your scheduled appointment may result in a charge of $75.00. for follow up appointments or $100.00 for wellness/annual physicals. Missed appointments represent the right to charge a fee for canceled or missed appointments. If you must cancel an appointment, Tualatin Internal Medicine, LLC requires a minimum of 24 hours notice.
- There is an administrative fee for completing forms such as DMV, physical forms, FMLA, leave of absence, disability etc. Most forms require 5 to 7 working days to research your information and complete the form.
- There may be additional charges applied to your account if we are asked to copy medical records per patient request or participate in a Deposition or Phone Consultation on your behalf.

Guarantor

- Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Insurance

- It is important for you to be an informed consumer, who understands the specifications of your insurance policy (eg, vaccine and doctor visit coverage, referral/authorization requirements for specialty care, radiographs, laboratory tests, urgent care facility care). Your health insurance policy is a contract between you and your health insurance company or employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations and limits on outpatient charges regardless of whether or not our physicians participate.
- You must present a current insurance card at each visit. As a courtesy to you, we will bill your insurance company directly for medical services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment of medical services rendered.

- If you do not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Tualatin Internal Medicine, LLC if your insurance pays the claim at a later date.
- If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "non-covered," in which case you are responsible for payment in full.
- You have responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed.
- If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.
- Tualatin Internal Medicine, LLC contracts with many insurance plans. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the cost of care.
- If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information about your plan that we relay to you is in good faith.

Medicare Patients

- Medicare may not cover some of the services that your doctor recommends. You may be responsible for some services not covered by Medicare.

Minors and Dependents

- Parent and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed.
- The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, it is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.

Non-Emergency Appointments

- Outstanding balances or failure to pay co-payments upon check-in may results in physicals and other routine or screening appointments being rescheduled.

Prompt Payment

- Just as we make every effort to accommodate you when you are in need to medical care, we expect that you will make every effort to pay your bill promptly. Payment is due at the time services are provided or upon receipt of a statement from our billing office.

Referrals and Authorizations

- Please be aware of and provide any required referrals or authorizations in advance of the appointment of service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt contact your plan directly for clarification.

Refunds

- A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office.

Self-Pay Patients

- Self-pay patients should be prepared to pay at the time of each visit.

Worker's Compensation

- The patient must provide at time of service: a claim number, name of the carrier, the date of injury, employer at time of injury and name and number of the claim adjuster. Without this information, the patient will be held responsible for all charges, and payment will be collected at time of service.

Printed name of Patient_____

Signature of Patient or Legal Guardian_____ Date: _____

Tualatin Internal Medicine, LLC
Primary Care

Patient Rights

As a patient and/or his/her legal representative of Tualatin Internal Medicine, LLC you have the right to:

- Receive considerate, respectful and compassionate care in a safe and secure environment that is free of all forms of discrimination, abuse or harassment, regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- You have the right to be informed of the name, identity and professional status of your primary healthcare provider, as well as the name, identities, professional status and professional relationship of other healthcare providers and team members involved in your care.
- Communications in a language and manner in which you understand. Interpreters will be provided when necessary.
- Have another person present during examination and/or treatment, unless that person's presence compromises your or others' rights, safety or health.
- To be told by your health care provider about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcomes of treatment in terms you can understand. You have the right to give written informed consent before any non-emergency procedure begins.
- Within the confines of law, review your medical records. All communications and records pertaining to your care will be treated as confidential.
- You can expect full consideration of your privacy and confidentially in care discussions, exams, and treatment.
- Agree to or refuse to participate in research.
- To make an advanced directive and appoint someone to make healthcare decisions for you if you are unable. If you do not have an advanced directive, we can provide you with appropriate information.
- Expect reasonable continuity of care
- Care will be free of restraints or seclusion that is not medically required
- Receive and examine an explanation of charges for services rendered, as well as receive detailed information regarding charges received.
- You, and others whom you elect, have the right to participate in decisions about your care, your treatment, and services provided, including the right to refuse treatment to the extent permitted by law.
- You have the right to voice your concerns about the care you receive.

Patient Responsibilities

As a patient and/or his/her legal representative of Tualatin Internal Medicine, LLC, you have the responsibility to:

- To provide complete and accurate information, including your full name, address, telephone number, date of birth, insurance carrier, and employer when required.
- To provide complete and accurate information regarding your health, including present condition, past illnesses, hospitalizations, medications (including over-the-counter products and supplements), allergies and sensitivities, and any other information that pertains to your health.
- Be an active participant in your care.
- You are expected to make it known whether you clearly comprehend a proposed treatment plan and what is expected of you, including whether you anticipate not following the prescribed treatments or are considering alternative therapies. Ask questions if you do not understand. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- Inform and report unexpected changes in your condition to the responsible practitioner in a timely manner
- You are expected to treat all clinic staff, other patients, and visitors with courtesy and respect. Be respectful of others and their properties while in Tualatin Internal Medicine facilities. Assist in the control of the noise, smoking, and number of visitors. Tualatin Internal Medicine does not allow weapons of any kinds on the premises.
- Keep appointment, be on time for your appointments and notify your physician as soon as possible if you cannot keep your appointments.
- Provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
- Failure to comply with the above may lead to termination from the practice.

Signature: _____

Date: _____

Acknowledgment and Consent

1understand that Tualatin Internal Medicine, LLC (referred to below as "The Practice") will use and disclose health information about me.

1understand 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, 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
- Perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care

1also 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.

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:_____ Date:_____

Patient signature

By:_____ Date:_____

Patient Representative

Description of Representative's Authority:_____

For administrative use only:

We are unable to obtain the patient's written acknowledge of our Notice of Privacy Practices due to the following reasons: Patient declined to sign Other:_____

_____ **Date:**_____

Signature of staff member

Tualatin Internal Medicine, LLC

www.tualatinmed.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Street Address: City, State, Zip code:

I permit Tualatin Internal Medicine, their physicians, medical assistants, and other personnel (Health Care Providers) to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care. List family members, friends and state the person's relationship to the patient.

Name	phone number	relationship

This authorization is limited to the following time frame, _____ to _____. If no dates are indicated, this form will remain in effect for one full year (365 days).

If at any time, you no longer want to discuss your health information with the individuals named above, I must notify my health care provider by contacting Tualatin Internal Medicine.

Patient Signature: _____ Date signed: _____

6485 SW Borland Rd.
Suite B
Tualatin, OR 97062

Tel. (503)272-8825
Fax (503)427-9321

Tualatin Internal Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Please Note: Copy Fee May Be Charged For Medical Records

Records From:

Facility/Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Dates and Type of information to disclose:

- 2 years chart notes prior from last date seen
- 5 years Imaging and lab results
- Please include all: Colonoscopy, DEXA, Mammogram, Immunizations, sleep study
- Specific Information requested:_____

Records To:

Facility/Doctor: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary of my protected health information to the physician/facility listing about.

X_____

Signature of Patient / Parent / Guardian or Authorized Representative Date

_____

Printed name of Authorized Representative / Relationship to patient

6485 SW Borland Rd Suite B, Tualatin, OR 97062
Phone 503-272-8825 Fax 503-427-9321

Tualatin Internal Medicine

Patient Questionnaire

Last Name:	**First Name:**	**DOB:**
Sex: ☐**M** ☐**F**	**Gender:** ☐**M** ☐**F** ☐**Other**	**Occupation:**
☐ **Single** ☐ **Partnered** ☐**Married** ☐ **Separated** ☐ **Divorced** ☐**Widowed**		
Previous Doctor:	**Date of last Physical Exam:**	

PERSONAL HEALTH HISTORY			
Immunizations	☐Tetanus	☐ Pneumonia/Pneumovax	☐ Hepatitis A
	☐Influenza (Flu)	☐ Prevnar 13	☐ Hepatitis B
	☐Gardasil (HPV)	☐ Shingles Vaccine/Zostavax	

Past or Present Medical History: (check all that apply to you)			
☐Alcohol/Drug problem	☐Emphysema/COPD	☐Liver Disease	☐Blood Clots
☐Anxiety	☐Heart-Coronary Artery Dis.	☐Prostate problem	☐ Neuropathy
☐Arthritis	☐Heart-Heart Failure/CHF	☐Psychiatric- Depression	☐Sleep Apnea
☐Asthma	☐High Blood Pressure	☐Psychiatric Disorder- Other	☐ Heart Murmur
☐Atrial Fibrillation	☐High Cholesterol	☐Seizure Disorder	☐Migraines
☐Dementia	☐Hypothyroidism (low)	☐Stroke	☐Hepatitis
☐Diabetes	☐Hyperthyroidism (high)	☐Ulcers of the Stomach	☐Diverticulosis
☐Cancer	☐Kidney Disease	☐STD/sexual infection	☐ Colon Polyps
Type: _____		☐Abnormal Pap Test	☐ Positive TB test
		☐Peripheral Artery Disease	

Surgeries (include year or age at time of surgery)		
☐Appendectomy	☐Tonsillectomy	☐C-Section (Cesarean)
☐Cardiac Bypass (CABG)	☐Hernia Repair	☐Hysterectomy-Partial
☐Cardiac Angioplasty/Stent	☐Prostate Surgery	☐Hysterectomy-Total
☐Gallbladder Laparoscopic	☐Vasectomy	☐Tubal Ligation
☐Gallbladder Open	☐Cataract Surgery: ☐Left ☐Right	☐Breast Surgery: ☐Left ☐Right
Orthopedic (type):		
Other Surgery:		

Last Name:_____ First Name:_____ DOB:_____

Screening Tests	Approx Date:			Approx Date:	
Cholesterol Test		☐Normal ☐Abnormal	Pap Smear		☐Normal ☐Abnormal
Colonoscopy		☐Normal ☐Abnormal	Mammogram		☐Normal ☐Abnormal
Prostate Test		☐Normal ☐Abnormal	Bone Density Test		☐Normal ☐Abnormal
Dental Exam		☐Normal ☐Abnormal			☐Normal ☐Abnormal
Eye Exam		☐Normal ☐Abnormal ☐Glasses ☐Contacts ☐Cataracts			

Medications: List prescribed and over-the-counter medications	
Drug Name:	Dose & Directions:

Allergies/Reactions to Medications:	
Drug Name:	Reaction/Comments:
Food/Environmental Allergies:	
Drug Name:	Reaction/Comments:

Last Name:_____ First Name:_____ DOB:_____

SEXUAL HEALTH	
☐Sexually active ☐Not currently sexually active ☐Never sexually active	# partners in past year:
History of Sexually Transmitted Infection? ☐No ☐Yes Type/date:	
Current contraception method:	
# of children:	**WOMEN**: # of pregnancies: # of miscarriages:

HEALTH HABITS AND PERSONAL SAFETY	
Exercise	☐Sedentary (No exercise) ☐Mild exercise (i.e., climb stairs, walk 3 blocks, golf) ☐Occasional vigorous exercise (i.e., work or recreation, 1-3x/week for 30 min.) ☐Regular vigorous exercise (i.e., work or recreation >3x/week for 30 min.)
Tobacco	**Cigarette use**: ☐Never ☐Former smoker: Quit date or age: ☐Current smoker: # packs/day: # years: Other tobacco use: ☐Pipe ☐Cigars ☐Chewing tobacco ☐Vape
Alcohol	Do you drink alcohol? ☐No ☐Yes: ☐0-1 time/month ☐2-4 times/month ☐every week Each week, how many: Servings of beer? ____ Glasses of wine? _____ Shots/mixed drinks?_____ When did you last have more than 4 drinks in one day? _____
Drugs	Have you used recreational or street drugs within the last 2 years? ☐No ☐Yes Have you ever used recreational drugs with a needle? ☐No ☐Yes Types of drugs used: *check all that apply:* ☐Marijuana ☐Methamphetamines ☐Cocaine ☐Heroin ☐Other:_____
Advanced Directives	Do you have an advanced directive? ☐No ☐Yes

Last Name:_____ First Name:_____ DOB:_____

FAMILY HEATH HISTORY			
Family Member		Age	Medical Conditions (indicate Healthy or: diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer & type)
Mother	☐ Living ☐ Deceased		
Father	☐ Living ☐ Deceased		
Grandmother *Mother's Side*	☐ Living ☐ Deceased		
Grandfather *Mother's Side*	☐ Living ☐ Deceased		
Grandmother *Father's Side*	☐ Living ☐ Deceased		
Grandfather *Father's Side*	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
Sibling ☐M ☐F	☐ Living ☐ Deceased		
	☐ Living ☐ Deceased		
	☐ Living ☐ Deceased		

Last Name:_____ First Name:_____ DOB:_____

Check if you are currently experiencing any of the following:

GENERAL:

	Fatigue
	Fever
	Weight gain > 10lbs
	Weight loss >10lbs

SKIN:

	Rash
	New/Changing skin lesions
	Nail changes
	Hair loss

EYES/EARS/NOSE/THROAT:

	Vision changes
	Decreased hearing
	Ear pain
	Ringing in ears
	Nasal congestion
	Nose bleeds
	Hoarse voice
	Sore throat
	Sneezing
	Sinus problems
	Lump in neck

RESPIRATORY:

	Wheezing
	Difficulty breathing
	Night sweats
	Bloody sputum
	Productive cough
	Dry cough
	Shortness of breath

MUSCULOSKELETAL:

	Joint pain
	Joint swelling
	Joint stiffness
	Muscle pain
	Muscle weakness

CARDIOVASCULAR:

	Chest pain
	Racing heart
	Irregular heartbeat
	Shortness of breath
	Leg pain with walking
	Ankle or Leg swelling
	Decreased exercise tolerance
	Awakening at night due to trouble breathing

GASTROINTESTINAL:

	Abdominal pain
	Change in bowel habits
	Constipation
	Diarrhea
	Nausea
	Vomiting
	Trouble swallowing
	Heartburn
	Acid reflux
	Rectal bleeding

HEMATOLOGIC:

	Easy bruising
	Prolonged bleeding
	Enlarged lymph nodes

NEUROLOGIC:

	Headaches
	Dizziness/vertigo
	Numbness/tingling
	Passing out
	Difficulty walking
	Seizures
	Tremor
	Frequent falls

PSYCHIATRIC:

	Depression
	Anxiety
	Hallucinations
	Mood swings
	Suicidal thoughts
	Insomnia/sleep problems
	Psychiatric treatment

ENDOCRINE:

	Change in appetite
	Cold or heat intolerance
	Increased thirst
	Changes in sex drive
	Hair loss or excess growth

ALLERGIC/IMMUNOLOGICAL:

	Allergy/Hayfever symptoms
	Itching
	Frequent infections
	Exposure to infection

BREAST:

	Breast lumps/mass
	Breast pain
	Nipple discharge
	Rash on breast

GENITOURINARY:

	Painful urination
	Frequent urination
	Blood in urine
	Loss of bladder control
	Difficulty passing urine
	Hernia

MEN:

	Difficulty starting stream
	Change in urine stream
	Penile discharge
	Testicular pain or mass
	Hernia

WOMEN:

	Pelvic pain
	Irregular periods
	Vaginal discharge
	Excessive vaginal bleeding
	Bleeding after menopause
	Vaginal dryness
	Hot flashes
	Pain with intercourse

Reviewed by/Date: _____

Name _____ Birthdate_____ Doctor _____ Today's Date _____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ❒ Yes ❒ No

Little interest or pleasure in doing things? ❒ Yes ❒ No

If you answered "Yes" to either question above, please answer all questions below.

During the past two weeks, how often have you been bothered by the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult

For Office Use Only: Total Score