NW Preventive and Primary Care

Demographic sheet

730 SE Oak St. Suite K, Hillsboro OR 97123
13112 NE Halsey St. Portland, OR 97230
(P)503.430.1057 (Fax)503.430.1085

PATIENT INFORMATION

Name: _____
(last) (First) (M.I.)

Physical Address: _____

City, State, Zip: _____

Mailing address: _____

City, State, Zip: _____

Date of Birth: _____

Marital Status: [ ] Married [ ] Single [ ] Divorced

Sex: [ ] M [ ] F

Preferred name: _____

Preferred pronouns: _____

Preferred Pharmacy: _____

Phone:
_____ **[ ] Cell[ ] Home[ ] Work**
(please circle preferred contact #)
_____ **[ ] Cell[ ] Home[ ] Work**
_____ **[ ] Cell [ ] Home [ ] Work**

Do you give permission to NWPPC to leave a message with Protected Health Information: Yes No
If yes, please circle what phone numbers we are able to leave detailed messages on: Cell Home Work

PATIENT EMPLOYMENT INFORMATION

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

EMERGENCY CONTACTS

Name	Relationship	Phone

EMAIL POLICY:

I understand that email is not secure for Personal Health Information (PHI) exchange and acknowledge that any emails sent to and from my provider are not protected under HIPAA.

Providers do not initiate new email exchange, nor should confidential information be exchanged via email. Email is used at the provider and staffs discretion. Our clinic does not use email as a form of contact between patient and provider.

I have read and understand the above statement **Initials:** _____

Email Address: _____

PRIMARY INSURANCE

Insurance Co. Name: _____
ID #: _____
Group/Policy ID #: _____
Subscriber's Name: _____
Subscriber's DOB: _____

SECONDARY INSURANCE ***(if applicable)***

Insurance Co. Name: _____
ID #: _____
Group/Policy #: _____
Subscriber's Name: _____
Relationship to Patient: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. *I understand that I am responsible for any amount not paid for by my insurance.*

It is the patient's responsibility to confirm their coverage and limitations prior to an appointment.

_____ _____

I have and read and understand the above statement

PATIENT/GUARDIAN SIGNATURE DATE

NW Preventive and Primary Care

Patient's Responsibility for Payment

As a service to our patients, NW Preventive and Primary Care (NWPPC), will submit charges for medical treatment to the patient's insurance company, where applicable. However, **the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.** If you do not have any medical insurance, you will be responsible for the bill at the time of service. Monthly statements will be sent when there is a patient balance and payment is expected on a regular basis.

NWPPC *may* attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

Quoted benefits and/or payment from insurance companies are not a guarantee of coverage. It is the responsibility of the insured to verify benefits and coverage from their insurance company.

Subject to additional fees:

- Insurance claims resubmission due to inaccurate/incomplete info provided by patients is $25
- Returned checks for insufficient fund NSF is $35 plus amount of check

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs, even if there is a pending lawsuit.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at NWPPC for medical care and treatment. I agree to pay all medical expenses within 90 days from the statement date, unless other arrangements have been made with NWPPC. I understand that any bill 90 days overdue will affect my ability to schedule an appointment until it is paid.

I authorize release of all my medical information to my insurance company and I authorize payment of all medical benefits by my insurance company to NWPPC.

Signature: _____ Date: _____

Patient or Guardian Signature

Consent and Policy Agreement

730 SE Oak St. Suite K, Hillsboro, OR 97123
13112 NE Halsey St. Portland, OR 97230
Ph:503.430.1057 Fax:503.430.1085 Website: www.nwppc.com

Medical Consent: My care as a patient is directed by a licensed supervising physician. I consent to services rendered and provided to me under the instruction of supervising staff physicians.

CONSENT FOR RELEASE OF INFORMATION

Release of Information to Physician, Referring Physician, Insurer, and Professional Review Organization: I authorize release of medical and related information, including alcohol, drug abuse and mental health records obtained in the course of diagnosis and treatment to the insured's insurance carrier(s), agencies and their intermediaries or carriers, if applicable, for the purpose of obtaining care, treatment or payment for services provided or to be provided. This information may be released via first class mail, facsimile or certified courier, as applicable. Authorization may be withdrawn at any time by written notification.

Social Security numbers: Are not collected. If given, it is for the purpose of patient identification, compliance with federal and state agency reporting requirements, and billing to insurance carriers and collection needs. Disclosure of the social security number information is voluntary. If I have provided this information, I authorize release for the purpose stated above.

Controlled Substance Policy:

Our primary care providers do not prescribe long term opiates or benzodiazepines for patients. Acute prescribing is determined on a case-by-case basis, at the providers discretion. The providers do not prescribe any controlled substances on your first visit to the clinic. The prescribing of stimulants (ie: ADHD medication) is also done on a case-by-case basis and after receiving past medical records indicating your diagnosis of ADHD. If being prescribed *any* controlled substance, a controlled substance agreement form must be signed before we are able to fill said medication. These medications require paper prescriptions and a follow up visit will be required to refill all controlled substances.

Cancellation & Missed appointments Policy

Our clinic has a **24 hour** cancellation policy. If an appointment is cancelled within in 24 hours patient will receive a verbal warning. *For all appointments cancelled/ rescheduled within 24 hours of an appointment will be marked as .5. (2 cancels within 24 hours = 1 no show, please see below)* Our clinic has a **3 strike policy** for returning patients at which point services may be terminated with our clinic.

***Missed appointments**:*

For *new* patients if the 1st appointment is missed patient will receive verbal warning with explanation of cancellation policy. If the 2nd appointment is missed we will not be rescheduling patient at our clinic.

For *returning* patients if an appointment is missed patient will receive verbal warning and explanation of cancellation policy at the time of rescheduling. If a *2nd* appointment is missed patient will receive a letter from our clinic informing of missed appointment and our office policy. If a *3rd* appointment is missed we will no longer be able to schedule patient at our clinic. Patient will be sent letter notifying of termination of services with our clinic.

If we are prescribing any medication for patient with terminated services a 30 day courtesy refill will be given.

- **Arrival 10 minutes *after* an appointment time will result in required rescheduling of appointment and may also be considered a no-show or failed appointment in which a warning will be incurred. *Appointments to establish care *require* check in 20 minutes prior to appointment time.**

HIPAA PRIVACY POLICY

I have been given the opportunity to review the "HIPAA" privacy policy. **Initials** _____

I agree to the above consents, authorizations to release information, financial agreement, controlled substance, HIPAA privacy, and cancellation/missed appointments policies that apply to the medical services provided for three years from the date shown below. I have read, fully understand, and agree to the above statements.

_____

Patient Signature Date

_____

Patient PRINTED name

Parent, Guardian, Responsible Party, Legal Representative

New Patient Health History

NAME: _____BIRTHDATE: _____
TODAY's DATE: _____ Date of last physical exam: _____

SURGICAL HISTORY

SEE ATTACHED LIST

Please list all past surgeries:	Doctor or location:	Date

MEDICATIONS

SEE ATTACHED LIST

List any medications you are taking:	Dosage	How many times per day?

ALLERGIES

List any medication allergies you have:	Reaction

SEXUAL ACTIVITY

Are you sexually involved currently? YES NO
Sexual partners is/are/have been MALE FEMALE
Birth Control Method:
☐None ☐Condom ☐Pill/IUD/ring/patch/injection ☐Vasectomy

TOBACCO USE

Do you currently use tobacco? YES NO
Have you ever used tobacco? YES NO
When did you start? _____
When did you stop? _____
How much do you smoke per day? _____
Have you ever been advised to cut down? YES NO
Have you been exposed to second hand smoke? YES NO
What type of tobacco do you use?_____

DRUG USE

Do you use recreational drugs? YES NO
Have you ever used IV (injectable) drugs? YES NO What type of recreational drugs? _____

ALCOHOL USE

Do you drink alcohol? YES NO What type of alcohol? _____ Drinks per day?_____
Have you ever been advised to cut down? YES NO
Have you ever felt guilty regarding your drinking? YES NO
Do you ever need an eye opener in the morning? YES NO

EXERCISE

Do you exercise? YES NO How many times per week? _____
What type of exercise? _____

OTHER

How many cups of coffee/ caffeine do you drink per day? _____
What percentage of the time do you wear your seatbelt? _____
How many hours of sun exposure do you get per day? _____

REVIEW OF SYSTEMS - Check all symptoms you *currently* have

General
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Sweats
- ☐ Weight Loss

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal
- ☐ Bowel Changes
- ☐ Poor appetite
- ☐ Rectal Bleeding
- ☐ Stomach pain
- ☐ Vomiting blood

Muscle/ Joint/ Bone Pain
- ☐ What location?

_____

Respiratory
- ☐ Cough
- ☐ CPAP use
- ☐ Oxygen use
- ☐ Shortness of breath
- ☐ Wheezing

Eye, Ear, Nose, Throat
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing ears
- ☐ Seasonal allergies
- ☐ Sinus problems

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep difficulties
- ☐ O.C.D
- ☐ Other:_____

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Swelling of ankles

Skin
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash

PAST MEDICAL HISTORY- Check conditions that you have had in the past

- ☐Asthma
- ☐ Atrial Fibrillation
- ☐Anemia
- ☐ Anxiety
- ☐Autoimmune Disorder
- ☐Biliary Cirrhosis
- ☐Blood Transfusions
- ☐Brain Tumor
- ☐Cerebrovascular Disease
- ☐Cirrhosis
- ☐ VA / Stroke
- ☐COPD
- ☐Colon Cancer
- ☐Coronary Heart Disease
- ☐Crohn's Disease
- ☐C R F
- ☐Depression
- ☐Diabetes – Type 1
- ☐Diabetes – Type 2
- ☐Diverticulitis
- ☐D V T
- ☐G I Bleed
- ☐G E R D
- ☐Hemochromatosis
- ☐Hyperlipidemia
- ☐Hypertension
- ☐Hypothyroidism
- ☐Hyperthyroidism
- ☐Hepatitis A
- ☐Hepatitis B
- ☐Hepatitis C
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Liver Disease
- ☐ M I
- ☐ Neurologic Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Peripheral Vascular Disease
- ☐ Peptic Ulcer
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Valvular Heart Disease
- ☐ U T I – Recurrent
- ☐ Varicose Veins/Phlebitis
- ☐ Respiratory disease
- ☐ HIV

Other: _____
_____
_____

FAMILY HISTORY- List blood relatives with the following problems including Mother, Father, Sister, and Brother

Blood disorder _____
Cancer _____
Diabetes _____
Heart Attack _____
High blood pressure _____
Kidney Disease _____
Mental Illness _____
Neurological Disease _____
Growth / Developmental Disorder _____
Thyroid Disease _____
Stroke _____
Skin Disease _____
Tuberculosis_____
Other _____

GYNECOLOGY HISTORY- FEMALE ONLY

At what age did you start your periods? _____

Do you still have periods? YES NO Year of menopause:_____

First day of your last period: _____

How is your menstrual flow? Light Moderate Heavy

Regular periods? YES NO

How long do they last? _____

How much time between your periods? _____

Any bleeding between periods? YES NO

Do you get painful periods? YES NO

When was the date of your last pap smear? _____
When was the date of your last mammogram? _____

Do you have a history of the following: (Please check if yes)

- ☐Abnormal pap smear tests
- ☐Abnormal mammogram
- ☐Cancer of the breast, cervix, ovaries, uterus
- ☐Leakage of urine
- ☐Ovarian cysts
- ☐Uterine fibroids

# of times have you been pregnant? _____
# of living children? _____
# of premature births? _____
# of abortions? _____
# of miscarriages? _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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