Northwest Family Medicine

Timothy R. Peters, MD Sarah M. Peters, MD Robert L. Larson, Jr., MD
605 Welch Street, Silverton Oregon 97381 | (503) 873-6987 | Fax (503) 873-8923

PATIENT REGISTRATION

A. Patient Demographic Information

Patient Identification **Today's Date**_____

First Name _____ M.I. ____ Last Name_____ Nickname_____

Sex: ☐ Male ☐ Female Date of Birth_____ Age____ SSN_____

Mailing Address_____ City/State/Zip_____

Home Ph_____ Work Ph_____

Cell Ph_____ Other Ph_____

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other

Name_____ DOB_____ Preferred Ph#_____

Address_____ City/State/Zip_____

Employer_____ Ph_____

Emergency Contact Information

Name_____ Relation_____ Phone_____

Address_____ City/State/Zip_____

B. Additional Information

Employment Status: ☐ Full Time Employment ☐ Part Time Employment ☐ Unemployed ☐ Retired ☐ Stay-at-home

Student Status: ☐ Student-Full Time ☐ Student-Part Time ☐ Not a student

Marital Status: ☐ Legally Separated ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other_____

Preferred Language: ☐ English ☐ Spanish ☐ Russian ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Native American ☐ Alaska Native ☐ Black or African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Asian
☐ Caucasian ☐ Hispanic ☐ Multi-Racial ☐ Unknown ☐ Other_____

Preferred Pharmacies & Location 1._____

2._____

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NextGen Healthcare Patient Portal

Patient Name:_____ Date of Birth:_____

NWFM has a way for patients to connect with us via a secure online account, NextGen Healthcare Patient Portal. By setting up this account online you can have access to the following:

EMAILING PRESCRIPTION REQUESTS

EMAILING MESSAGES AND QUESTIONS TO THE DOCTORS AND MEDICAL STAFF

SCHEDULING APPOINTMENTS (NOTE: TO CANCEL OR RESCHEDULE APPOINTMENTS PLEASE CALL THE OFFICE)

RECEIVE LAB AND IMAGING RESULT LETTERS

VIEW YOUR CHART INFORMATION

VIEW BILLING STATEMENTS

If you would like to set up an account please provide us with your email address. Upon receiving enrollment instructions, follow the instructions to complete your enrollment. Please remember the information you set up your account with. (i.e.: username, password and the answer to your security question)

Email:_____

If you would like any dependents/family members to be on your account please provide their names and date of births._____

_____

Please notify us, if at any time, you would like someone removed from your account.

By signing, I give my consent to receive online medical information and account information for any of the members on the account._____

OR

If you have a family member that already has a Patient Portal account here and you would like to be added to their account please provide their name and date of birth._____
Please notify us, if at any time, you would like to be removed from their account.

Northwest Family Medicine Notice of Privacy Practices

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 11/14/2012, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of Notice effect for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

The law requires your doctor, hospital, or other health care provider you see in person to ask you to state in writing that you received the notice. Often, that means the doctor will ask you to sign a form stating that you received the notice that day. The law does not require you to sign the acknowledgement of receipt of the notice. Signing does not mean that you have agreed to any special uses or disclosures of your health records. Refusing to sign the acknowledgement does not prevent the entity from using or disclosing health information as the Rule permits it to do. If you refuse to sign the acknowledgement, the provider must keep a record that they failed to obtain your acknowledgement.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you have us a written authorization, we cannot use or disclose your health information for any reason except for those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree with written consent that we may do so.

Persons Involved with Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. IF you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference f you best inters in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health and safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials, health information required for lawful intelligence, counterintelligence and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail, postcards or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. We may charge you a reasonable cost based fee for expenses such as staff time, supplies and postage. If you prefer, we will prepare a summary of explanation of your information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, healthcare operations and certain other activities up to six years from today's date. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handles under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be made in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the US Department of Health and Human Services.

We support the right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Services.

For Complaints to the US Department of Health and Human Services

Region X - Seattle (Alaska, Idaho, Oregon, Washington)
Linda Yuu Connor, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Voice Phone (800) 368-1019
FAX (206) 615-2297
TDD (800) 537-7697

For Complaints or Further information from Northwest Family Medicine

605 Welch Street
Silverton, OR 97381
Phone:503-873-6987
Fax:503-873-8923

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to receive this office's Notice of Privacy Practices and understand I may refuse to sign this acknowledgement.

_____ _____
Print Patient Name Date of Birth

_____
Print Legal Guardian's Name (if patient is under 18 or medically unable)

_____ _____
Patient *or Legal Guardian Signature* Today's Date

Please indicate the family members or other persons, if any, which we may inform about your general medical condition and diagnoses (including treatment, payment, health care operations, appointments or anything in the entire medical record):

- ❑ Do not allow anyone except myself (the patient) access
- ❑ Patient's Spouse_____
- ❑ Patient's Parents_____
- ❑ Patient's Children_____
- ❑ Other_____

Please write the names on the lines.

Is there any health information you do not want disclosed? No____ Yes____

Please explain if Yes:_____

Please make up a password for our office. You may be asked for it if you call in for health information, to verify you are the one calling. Please also put down a hint that relates with your password that we may prompt you with in the event that you forget your password.

PASSWORD: _____
HINT: _____

Northwest Family Medicine

Agreements & Policies

Authorization and Agreements for Treatment, Emergency Care, or Out Patient Services at NWFM

1. **Consent to Treatment:** I hereby grant consent for treatment or services to be provided by the physicians and employees of Northwest Family Medicine, and I also certify that no guarantee or assurance has been made as to the results which may be obtained.

2. **Consent to Treat Minor:** I am the parent or legal guardian. I hereby consent to treatment or to services to be provided by the physicians and employees of Northwest Family Medicine.

3. **Release of Medical Information:** I hereby authorize Northwest Family Medicine to release any medical information or charges in connection with these services to, but not limited to, an insurance carrier, workmen's compensation carrier, medical service companies, Health & Welfare Funds or the patient's or responsible parties employer.

4. **Insurance Assignment:** I hereby assign medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any party liable for the patient's care to Northwest Family Medicine for application to the patient's bill.

5. **Financial Agreement:** For and in consideration of the care and treatment provided to the patient, I agree to pay Northwest Family Medicine all charges for services rendered to or in behalf of the patient.

6. **NextGen EMR:** Limited information is shared between NextGen providers, including medications, diagnosis and drug allergies. To allow for continued sharing which may include mental health medications and diagnosis; **INTIAL** _____

Office Policies and Practices

1. We remind you that your medical insurance is a contract between you and your insurance company and does not affect your responsibility to our office for prompt payment.

2. We may furnish information to insurance companies regarding services rendered.

3. As a service to our patients, most insurance companies will be billed.

4. Minimum payment on account balances less than $200.00 will be $20.00

5. Minimum payment on account balances over $200.00 will be 10% of the balance.

6. There will be a $3.00 re-billing fee assessed if minimum payment is not made within the billing cycle.

6. Accounts past due for 60 days will be forwarded to a collection agency.

7. A $15.00 charge will be assessed for any NSF check received as a payment on accounts.

8. A $25.00 charge will be billed directly to patient for missed appointments. A $50.00 charge will be billed directly to the patient for missed Wellness Exam/Physical appointments. These fees are not paid by insurance and are the direct responsibility of the patient.

By signing below, I acknowledge that I fully understand and agree to the policies and practices of this office. I also agree that all the information provided is true to the best of my knowledge. I also hereby authorize the payment of insurance benefits for professional services rendered to NWFM Physicians, 605 Welch Street, Silverton, OR 97381.

_____ _____

Print Patients Name Patients Date of Birth

_____ _____

Signature of Patient/Parent/Guardian Date

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HEALTH HISTORY AGES 0-17

Please take the time to fill out this confidential form to the best of your ability so that we may better serve you. Thank you.

Child's Name _____ Today's Date _____
Date of birth _____ Age _____
What is your reason for this visit? _____

ALLERGIES (*include food and drug allergies*):

Date	Medication/Allergen	Your Reaction

MEDICATIONS (*list current medications and doses*):

PAST MEDICAL HISTORY

Date of onset	Chronic Problems

SURGERIES/HOSPITALIZATIONS

Date	Type of Surgery/Nature of Hospitalization

FAMILY HISTORY

Medical Problem	Family Member	Age of Death	Cause of Death

SOCIAL HISTORY

The child's parents are:
☐ Married ☐ Unmarried, but living together ☐ Separated ☐ Divorced

The child lives with (*check all that apply*):
☐ Mother ☐ Father ☐ Siblings ☐ Other: _____

Father's occupation		Mother's occupation	
Does anyone smoke in the household?		Any concerns regarding lead exposure?	
What school does your child attend and what grade?		Any firearms in home?	
Does your family have any spiritual beliefs?		Is your child in daycare?	

SYMPTOMS (*check yes or no regarding the following symptoms in the past week*):

Yes	No		Yes	No	
☐	☐	Fever	☐	☐	Diarrhea
☐	☐	Irritability	☐	☐	Constipation
☐	☐	Not eating well	☐	☐	Decreased urine output
☐	☐	Seeing or hearing problems	☐	☐	Blood in urine
☐	☐	Eye or ear discharge	☐	☐	Rash or itching
☐	☐	Cough	☐	☐	Sleeping problems
☐	☐	Wheezing	☐	☐	Bleeding problems
☐	☐	Trouble breathing	☐	☐	Food allergies
☐	☐	Vomiting	☐	☐	Behavioral problems

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HEALTH HISTORY AGES 18 AND OLDER

Please take the time to fill out this confidential form to the best of your ability so that we may better serve you. Thank you.

Legal Name _____ Today's Date _____

Date of birth _____ Age _____

What is your reason for this visit? _____

ALLERGIES (*include food and drug allergies*):

Date	Medication/Allergen	Your Reaction

MEDICATIONS (*list current medications and doses*):

PAST MEDICAL HISTORY

Date of onset	Chronic Problems

SURGERIES/HOSPITALIZATIONS

Date	Type of Surgery/Nature of Hospitalization

SYMPTOMS (*check yes or no regarding the following symptoms in the past week*):

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Fatigue	☐	☐	Chest pain	☐	☐	Pain with urination	☐	☐	Itching
☐	☐	Fever	☐	☐	Irregular heart beat	☐	☐	Blood in urine	☐	☐	Rash
☐	☐	Night sweats	☐	☐	Leg cramps with walking	☐	☐	Too cold	☐	☐	Bone/joint pain
☐	☐	Visual changes	☐	☐	Abdominal pain	☐	☐	Too hot	☐	☐	Muscle weakness
☐	☐	Eye discharge	☐	☐	Constipation	☐	☐	Increased thirst	☐	☐	Off balance
☐	☐	Ear discharge	☐	☐	Diarrhea	☐	☐	Increased hunger	☐	☐	Easy bruising or bleeding
☐	☐	Hearing loss	☐	☐	Vomiting	☐	☐	Increased urination	☐	☐	Hay fever
☐	☐	Nasal drainage				☐	☐	Depressed	☐	☐	Food allergy
☐	☐	Cough				☐	☐	Anxious			
☐	☐	Wheezing or short of breath									

NAME_____ **Date of birth**_____

SOCIAL HISTORY

Level of education completed		Occupation	
Degree		Occupational Hazards	

Do you smoke tobacco?		How much alcohol do you drink?	
How much per day do you smoke?		Are you married, single, divorced, widowed, other?	
For how many years?		Do you have a religious affiliation or spiritual beliefs?	*Yes* *No*
Have you ever tried to quit?		Is this an important part of your life?	*Yes* *No*

Do you have advance directives in place (*check one*)?

☐ None ☐ Living will ☐ Healthcare by proxy
☐ DNR ☐ Durable power of attorney

FAMILY HISTORY

Medical Problem	Family Member	Current Age	Age of Death	Cause of Death

HEALTH MAINTENANCE (*please give approximate dates*)

Last Physical Exam		Last Pap Smear		Influenza Vaccine	
Last Lipid Panel		Mammogram		Pneumococcal Vaccine	
Colonoscopy		Bone Density Scan		Tetanus Vaccine	

WOMEN'S HEALTH HISTORY

Age when periods started		Are you currently pregnant?	
Age when first child was born		Are you postmenopausal?	
Date of last menstrual period		Age of menopause	

PREGNANCY HISTORY *(please include all abortions, miscarriages, or adoptions)*

Year of Birth	Boy or Girl?	Weight	Vaginal or C-Section?	Complications

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

PATIENT NAME:

Name_____ Previous Name_____ Date of Birth_____

I, THE PATIENT/GUARDIAN, AUTHORIZE

Name of Provider_____ Ph_____ Fax_____

Address_____ City/State/ZIP_____

TO DISCLOSE MY MEDICAL RECORDS TO:

Name_____ Ph_____ Fax_____

Address_____ City/State/ZIP_____

INFORMATION TO BE DISCLOSED:
☐Chart note(s)
☐Laboratory Report(s)
☐Diagnostic Imaging Report(s)
☐Everything (chart notes, labs, imaging, specialized testing, vaccine record, growth charts)
☐What time period do you want disclosed?_____
☐Other_____

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.

_____**Alcohol/Drug Abuse**
_____**HIV/Aids Test Results**
_____**Mental Health/Developmental Disabilities**
_____**Genetic Testing**

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDs information, mental health information, genetic testing information and drug/ alcohol diagnosis, treatment or referral information.

PURPOSE for release of records _____

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.

Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have read this information and understand it. (Please print, sign name and date below)

Please print your name if you are signing but are not the patient._____

Signature_____ Date_____