REGISTRATION FORM

(Please Print)

Today's date:	Date first visit:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Wid
Social Security #:	Date of Birth: ___/___/____		
Street address:	Home phone: ( )		Cell phone : ( )

City:	State:	Zip Code:	Email Address:
Occupation:	Employer Name		Employer phone no.: ( )

How did you hear about us?: (check one)

❑ Family ❑Friend ❑Close to home/work ❑Dr. ❑Insurance Plan ❑ Hospital ❑Other, please specify: _____

How would you like us to remind you of your appointments?	❑ Home Phone ❑ Cell Phone ❑ Email ❑ Text Message – name of carrier _____

May we leave a voicemail? (circle one) yes or no

PAYMENT AND INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for account:	Birth date: ___/__/____	Address (if different):	Home phone no.: ( )
Relationship to Patient:	Driver's License #:		State:
Occupation:	Employer Name:		

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Insurance Company:

Name of the Insured:	Soc Sec #:	Birth date: ___/__/____	Group no.:	Policy no.:	Copay:
Patient's relationship to subscriber:	❑ Self ❑Spouse ❑ Child ❑ Other				

Additional/Secondary Insurance

Name of Insurance Company:

Name of the Insured:	Soc Sec #:	Birth date: ___/__/____	Group no.:	Policy no.:	Copay:
Patient's relationship to subscriber:	❑ Self ❑Spouse ❑ Child ❑ Other				

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Care Plus You to release any information required to process my claims.

Patient/Guardian signature Date

Care Plus You

Assignment of Benefits Form

Financial Responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments. As a courtesy we will bill third party payers (such as auto insurance related to motor vehicle accidents) when provided with complete insurance information at time of service. Balances for third party claims are subject to the same payment terms as other services received at Care Plus you. If you are unable to pay within 30days of receiving service please contact our office to set up a payment plan. Accounts may be assigned to an outside collection agency and reported to the credit bureaus when the personal balance is over 120days old and/or payment plan payments are missed. Patients whose account has been assigned to outside collections are responsible for all agency and/or legal fees incurred. Thereafter future services are on a cash basis with no extension of credit and may also be subject to dismissal.

Additional Fees:

1.5% monthly finance charge added to accounts with personal balance over 60days

$40 No Show. A 24- hour notice must be given to avoid the No-Show fee. For all OHP patients: After your 1st no-show, we will contact to reschedule your appointment. On the 2nd no-show, your insurance carrier will be notified. On your 3rd no show, we have the right to discharge you from our facility. $25 Returned Check. Added to accounts for which check payment is not honored by the bank. $50 Collection. Added to accounts assigned to an outside collection agency

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment checks directly to **Care Plus You** for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions. We cannot quote nor do we guarantee insurance benefits.

Authorization to Release Information:

I hereby authorize **Care Plus You** to:

1. Release any information to necessary insurance carriers regarding my illness and treatments
2. Process insurance claims generated in the course of examination and treatment
3. Allow a photocopy of my signature to be used to process insurance claims for the period of lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from **Care Plus You** on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable at the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Please Print Name_____

Patient / Responsible Party Signature_____Date_____

Witness_____Date_____

Care Plus You Health Assessment: Please fill out to the best of your ability.

Printed Name:_____DOB:_____

Family History: Please indicate if your blood relatives have had any of the following:

Illness	Relation	Illness	Relation
Addiction/Substance Abuse		Glaucoma/Eye Disease	
AIDS or HIV		Heart Disease	
Arthritis		High Blood Pressure	
Asthma		Kidney Disease	
Bleeding Disorder		Lung Disease	
Bowel Disease		Psychiatric Care	
Epilepsy/Convulsions		Stroke	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Cancer type_____		Other?_____ _____	

Social Habits: Have you used any of the following?

Substance	Check one	Amount per day?	For How Long?	When stopped?
Alcohol	Yes___ No___			
Tobacco products	Yes___ No___			
Caffeine	Yes___ No___			
Street Drugs Type_____	Yes___ No___			

- Do you exercise safe sex precautions? Yes___No____ Would you like info on safe sex precautions? _____

Are you allergic to any medications? Yes _____ No_____ If answer is yes, please describe below:

Medication Name	Describe the reaction (i.e. hives, rash)

Please list medications you are currently taking: (please include over-the-counter, supplements, and contraceptives)

Medication Name	Strength/Dosage	Frequency	Reason Why?

Signature of Patient or Guardian_____Date_____

Care Plus You Health Assessment: Please fill out to the best of your ability.

Printed Name:_____DOB:_____

Past Medical History: Please indicate if you have been diagnosed with any illnesses below by checking the box. Please write the approximate date of diagnosis (Month/Year).

Illness	✓	Date of Diagnosis	Illness	✓	Date of Diagnosis
Addiction/Substance Abuse			Hepatitis (type_____)		
AIDS or HIV			High Blood Pressure		
Anemia			High Cholesterol		
Alcoholism			Hernia		
Allergies (not medication)			Kidney Disease/Failure		
Anorexia/Bulimia			Liver Disease		
Appendicitis			Lung Disease		
Arthritis			Measles		
Asthma			Migraines		
Cancer			Mono		
Chicken Pox			Pneumonia		
Cataract			Psychiatric Care		
Depression			Rheumatic Fever		
Diabetes			Ovarian Cysts		
Esophageal Reflux			Stomach Ulcer		
Emphysema/COPD			Sexually Transmitted		
Epilepsy/Convulsions			Stroke/Ministroke		
Frequent Kidney or Bladder Infections			Thyroid Problems (type_____)		
Frequent Lung Infection			Tonsillitis		
Gallbladder Disease/Gallstones			Tuberculosis		
Gout			Whooping Cough		
Glaucoma/Eye Disease					
Heart Disease					

Surgical History: Please list any other operations, hospitalizations, or procedures you have had with date. (MM/YY)

Surgery/Hospitalization	Date	Please Describe	Surgery/Hospitalization	Date	Please Describe

Signature of Patient or Guardian_____Date_____

NOTICE OF PRIVACY PRACTICES

I understand that Care Plus You 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 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, and 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; 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-effective 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 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 <u>have received</u> a copy of the Notice of Privacy Practice
Patient Name (please print):
_____

-OR-

By:_____ Date:_____
(Patient Sign if 15 years old or older)

By:_____ Date:_____
(Patient representative sign if patient is under 15)
Description of Representative's Authority (Mother, Father, Guardian…):_____

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

In order to be valid, this form must be completed in full including signature(s) and date(s) wherever applicable.

Patient's Full Name_____ Date of Birth ____/____/_____

Address_____City_____State_____Zip_____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____

I authorize (select one clinic):**Central Fax : Care Plus You 1800 Blankenship Rd Ste 350 West Linn Or 97068 Phone:503-213-6600 Fax:971-350-7350**

ATTN: Medical

Clinic/Provider/Other Name:_____

Select One and complete right Ö: Address: _____

__ To forward records to: City: _____State: _____ Zip: _____

__To receive records from:

__ To verbally exchange with: Phone: (_____)_____ Fax: (_____)_____

Purpose of release (check only one): __Change healthcare provider __ Consultation __Legal
__ Other: _____

By **initialing** in the spaces below, I specifically authorize the release of that specific medical information:

____ Clinician office chart notes ____ Immunization history ____ Hospital reports
____ Diagnostic Imaging reports (X-rays…) ____ Laboratory reports ____ 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.

_____ HIV/AIDS _____Mental Health/ADD/ADHD diagnosis, treatment or referral

_____ Genetic testing information _____ Drug/Alcohol diagnosis, treatment or referral information

The medical information authorized above (check only one) __ **MAY** or __ **MAY NOT** be faxed. I understand there is a risk in faxing records and confidentiality cannot be guaranteed.

My signature below indicates that I understand and agree to the following:

- The information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, 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.
- The person or entity I am authorizing to use and/or disclose the information may receive compensation for doing so.
- I may refuse to sign this authorization. Refusal to sign the authorization will not adversely affect my ability to receive
  health care services or reimbursement for services. The only circumstances when refusal to sign means I 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.
- This is not a blanket authorization for release of information. It is intended for one-time use only. I must re-execute it should additional requests for information occur. This authorization may be revoked at any time unless prior action has been taken as a result of this form. Unless revoked earlier, this consent will expire in 180 days from the

date of signing.

- That proof of guardianship or a court order may be required if signing for a person under 18 years of age.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN	RELATION TO PATIENT	DATE

PRINTED NAME OF PATIENT/PARENT/LEGAL GUARDIAN