



REDWOOD
FAMILY PRACTICE

Welcome

Thank you for choosing Redwood Family Practice for your health care.

Our goal is to provide you with quality patient care. Please complete the enclosed patient information and return to our office. We appreciate receiving the information in advance of your appointment so we can begin your medical record. Once the information is received, we can schedule your new patient appointment.

Your first visit will be to establish care, review your medical history, document your medical needs and develop a plan for care. If you have coverage for an annual or wellness exam, this will be scheduled after your initial visit. Your annual or wellness visit is the time to discuss your goals to improve your health and personal goals for the following year.

Please bring all medications and supplements with you to the first visit. Redwood Family Practice providers are not accepting patients for pain management. We will care for your other medical needs and we will make a referral to a pain specialist if needed.

Our office is contracted with many insurance carriers. To avoid any confusion, please contact your insurance carrier to confirm Redwood Family Practice is contracted with them. We are happy to help you.

Redwood Family Practice and staff look forward to meeting your medical health care needs.

214 NE Outlook Ave
Grants Pass, OR 97526

Patient Information

Last Name _____ First _____ Middle _____

Date of Birth _____ SS# _____ Cell Phone _____

Primary Language _____ Home Phone _____

Email _____ Work Phone _____

May we leave medical and appointment information on your cellphone/answering machine?

Yes No

Street Address _____

City _____ State _____ Zip _____

Mailing address (check if same as Street address) _____

City _____ State _____ Zip _____

Marital Status Single Married Divorced Widowed Domestic Partner

Spouses Name _____ Date of Birth _____ Phone _____

OHRP Information (required by the State)

Ethnicity Hispanic/Latino Non-Hispanic/Latino Decline
 Asian Black/African American American Indian
 Alaskan Native Hawaiian/Pacific Islander White/Caucasian

Employment

Full time Part time Not employed Student Retired

Emergency Contact

Name _____ Relationship _____

Address _____ Phone _____

If patient is a child, parent's name _____ Phone _____

Insurance

Primary _____ Secondary _____

Subscriber name _____ Subscriber name _____

Date of birth _____ Date of birth _____

ID# _____ Group# _____ ID# _____ Group# _____

I authorize treatment of the person named above and accept financial responsibility for all treatment provided. I authorize Redwood Family Practice to provide my insurance companies with all information necessary to process insurance claims and assign payments to Redwood Family Practice all of the insurance benefits due to me to the full extent of my financial obligation. A photocopy of this authorization shall be considered as a valid as the original.

I have read and understand all of the above.

Signature _____

Date _____

Health History

Name _____ Date _____

Date of birth _____ Referred by _____

Are you under the care of any other physician/provider? Yes No

Please list other health care providers _____

Social History

Do you use tobacco? Yes No Average amount (daily, weekly, monthly) _____

Do you drink alcohol? Yes No Average amount (daily, weekly, monthly) _____

Exercise: None Moderate Daily Heavy

Women Only

First menstrual cycle (age) _____ Present form of birth control _____

Date of last menstrual cycle _____

of pregnancies _____ Full-term _____ Live births _____

Date of last mammogram _____ Date of last pap smear _____

Men Only

Date of last prostate exam _____ Date of last PSA test _____

Past Medical History (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psoriatic Arthritis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Rotator Cuff Injury |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cataracts/Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Significant Weight Changes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sinus Headaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Torticollis |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Genetic Spinal Disorder | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pinched Nerves | |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Polio | |

Date of last colonoscopy _____ Date of last Dexa Scan _____

Diabetic Patients

Date of last foot exam _____ Date of last eye exam _____

Date of last A1c _____ Date of last cholesterol panel _____

Health History (continued)

Name _____ Date of Birth _____ Today's Date _____

Previous Surgeries

Type	Year	Surgeon	City
1. _____			
2. _____			
3. _____			
4. _____			
5. _____			
6. _____			
7. _____			

Family History

If Living
Father Age _____ Health _____
Mother Age _____ Health _____

If Deceased
Father Age _____ Cause _____
Mother Age _____ Cause _____

of your children _____ # living _____ # deceased _____

Ages of each of your children _____

Serious illnesses of children _____

Family Medical History (Please check and note relationship. If grandparent, please specify maternal or paternal.)

- Coronary artery disease
- Heart rhythm
- Heart infections/Inflammation
- Heart malformations
- High blood pressure
- Cancer (type/location) _____
- Diabetes Type I
- Diabetes Type II
- Hypothyroidism
- Heart muscle disorders
- Psychiatric condition

HIPPA Laws Policy and Procedure

I have had a chance to review and have been offered a copy of the HIPPA Laws policies and Procedures.

Signature: _____ Date: _____

DISCLOSURE OF FEES AND PAYMENT POLICY

I understand that all fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctor's specific recommendations. I also understand there is one fee schedule for all services rendered in this office. There is a 30% discount if you pay in full at time of service. If I desire, a complete list will be available at any time. All fees are subject to change without notice.

I understand If I have extenuating circumstances, I can speak with the office manager and apply for a hardship account; which I will be given and application and if I qualify, I will receive a reduced fee for services rendered specifically geared to my financial income.

I Authorize Redwood Family Practice to receive direct payment from my insurance company or attorney for all monies due on my account. I understand that I am responsible for insurance deductibles, co-pays and any portion of the bill not paid for by the insurance company due and payable on the day the services are rendered. I authorize My signature, below, to be kept on file and used as "my signature on file" to process all insurance claim submissions. I also authorize the release of medical or other information necessary to process all insurance claims.

I hereby assign all medical benefits to which I am entitled to Redwood Family Practice. I authorize any of their employees to sign for me on the back of any draft or check which they receive for services rendered from any insurance company, whether pursuant to medical payments coverage or health insurance coverage, as long as I have an outstanding balance with them. Said amount shall be credited against my account and shall reduce my outstanding balance accordingly. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

I fully understand and agree to the above terms and acknowledge that I am ultimately responsible for any and all monies owed to Redwood Family Practice regardless of the outcomes of any court case or denials by an insurance company. Should I receive any payment(s) or settlements for services rendered, I will forward those on to Redwood Family Practice within 5 days, or be immediately responsible for the entire amount billed.

Signature _____ Date _____

Consent to Release Protected Health Information to Friends or Family Members

Patient Name _____ Date of Birth _____

I request Redwood Family Practice to release protected healthcare information to:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

This request and authorization applies to:

All healthcare information (Medical and Billing)

Healthcare information relating to the following treatment, condition, or dates:

Other _____

I understand that this designation applies only to Redwood Family Practice.

Patient Signature _____ Date _____

REVOCCATION/TERMINATION

I request to revoke/terminate the designation made above.

Patient Signature _____ Date _____

Patient Financial Policy

Redwood Family Practice provides quality health care and administers all accounts under the following guidelines.

Insurance Billing: As a courtesy to our patients with insurance, upon receipt of the appropriate insurance information, we will submit your insurance claim for you. Patients are responsible for all deductibles, copayments and other patient balances as indicated by your insurance carrier. Office visit copays are due at the time of service. It is the responsibility of the patient to know what their insurance benefits are.

Cash Pay Accounts: Patients without insurance must pay at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements. In no instance do we carry an account balance beyond 3 months from the date of service.

Auto Accident: We will bill for motor vehicle accidents, but only as a courtesy. If your motor vehicle insurance carrier does not pay or does not pay in a timely manner, then payment in full is your responsibility. We will supply any information that may be needed for you to submit to your motor vehicle insurance.

Liability Injury: If your injury is a result from another party's negligence, you are required to pay for services and then collect from the responsible party. We not file a claim to the insurance, but we will provide you with needed information and receipts to file the claim.

Workers Compensation: If your injury is due to an accident in your work place, please inform the front office person before you see your provider. It is your responsibility to know your employer's worker's compensation insurance information (name and billing address).

In the event that your account must be referred to a third party for collection, patient agrees to pay all reasonable collection and/or attorney fees, as well as court costs incurred.

Payment Methods: Payment methods include Cash, Check, MasterCard, Visa and Care Credit. A \$35 fee will be assessed by our office for any returned checks in addition to the service charge assessed by our bank.

Forms: There are fees for forms that the providers are asked to complete. In some instances, the provider may ask you to make an appointment to properly complete the form. Form completion fees are not covered by insurance and are to be paid at time of form request. Please check with our staff for form fees.

Monthly Billing Statements: After your insurance has processed your claim any unpaid patient balances are due upon receipt of our billing statement. In no event will an account balance exceed 3 months. If you have special financial needs, please contact our office manager.

Signature/Patient or Guardian

Date

No Show Policy

A “no show” is someone who misses an appointment without canceling it 24 hours in advance. No shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in our schedule as a “no show”. The first time there is “no show”, you will be sent a letter alerting you to the fact that you have failed to show up for an appointment and did not cancel the appointment. If you have three “no shows” in one year, you will be dismissed from Redwood Family Practice.

In order to be respectful of the medical needs of all our patients please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of all our patients.

If it is necessary to cancel your appointment, we require that you call 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

To cancel and reschedule your appointment, please call our office: 541 474-5665.

Late cancellations are considered a “no show”.