REDWOOD
FAMILY PRACTICE

1619 NW Hawthorne Ave.
Grants Pass, OR 97526
(541) 474-5665

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.

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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

Mailing address:_____

City:_____ State:_____ Zip:_____

Employment

☐ Full time ☐ Part time ☐ Not employed ☐ Student ☐ Retired

Place of Employment:_____ Occupation:_____

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
☐ Alaska Native ☐ Hawaiian/Pacific Islander ☐ White/Caucasian

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

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Health History

Name:_____ Date:_____

Date of Birth:_____ Referred by:_____

Please list other physician/provider:_____

Social History

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

Do 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:_____

Men Only

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

Past Medical History *(check all that apply)*

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

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:_____

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Health History *(continued)*

Name:_____ Date of Birth:_____ Date:_____

Previous Surgeries

Type	Year	Surgeon	City

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

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Medication

Preferred pharmacy:_____

Allergies & Reactions *(please include medications, foods, latex, dye, etc.)*

_____

_____

Current Medication *(list all medications, including prescriptions, vitamins, over-the-counter, herbs & supplements)*

Medication	Dose	Frequency	Reason for taking

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HIPAA LAWS POLICY & PROCEDURES

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 Current Medication

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 _____

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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.

_____ _____
Signature Date

Revoccation/Termination

I request to revoke/terminate the designation made above.

_____ _____
Signature Date

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Release of Healthcare Information

Patient Name:_____ Date of Birth:_____

Address:_____ Phone:_____

Released from:

Facility Name:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax #:_____

Released to:

Facility Name:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax #:_____

Purpose of release: ☐ Transfer of Care ☐ Referral/Consultation ☐ Personal

By **initialing the spaces below**, I specifically authorize the release of the following medical records, if such records exist.

___ All medical records *(limited to 2 years unless otherwise indicated)*

___ Hospital

___ Physical Therapy

___ Laboratory/and or pathology reports

___ Diagnostic imaging reports

___ Emergency and urgent care records

___ Billing Statements

___ Other:_____

___ Healthcare relating to the following condition or treatment dates:_____

I understand and agree that the information below will be disclosed if I **place my initials** in the applicable space next to the type of information.

___ HIV/AIDS testing/treatment

___ Genetic Testing

___ Mental Health specific visits

___ Drug/Alcohol specific visit

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time giving written notice to Redwood Family Practice. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer be protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation *(either directly or indirectly)* for doing so.

This authorization will expire 90 days after signing.

_____ _____

Signature Date

_____ _____

Print Name or Legal Representative *(if applicable)* Date

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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".

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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/Patent or Guardian Date