

#### 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.

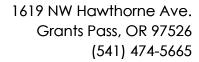
Redwood Family Practice and staff look forward to meeting your medical health care needs.



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

## **Patient Information**

Last Name:		First	First: N		Middle:	
Date of Birth:			SS#:C			e:
Primary Language:			Home Phone:			
Email:			Work Phone:			
May we leave med	ical and appoint	ment inforn	nation on your cell	ohone/answeri	ng mach	nine? 🗆 Yes 🗆 No
Mailing address:						
City:			Stc	ate:	Zip:_	
Employment						
☐ Full time	$\square$ Part time	$\square$ N	ot employed 🗆 Student		nt	$\square$ Retired
Place of Employ	ment:		Oc	ccupation:		
Marital Status:	☐ Single	□Married	□ Divorced	□Wido	wed	☐ Domestic Partner
Spouses Name:			Date of Birth:		Phon	e:
OHRP Informatio	<b>n</b> (required by th	e State)				
Ethnicity: Hispanic/Latino  Asian  Alaska Native			<ul><li>□ Non-Hispanic/Latino</li><li>□ Black/African American</li><li>□ Hawaiian/Pacific Islander</li></ul>		ΔA	
Emergency Con	tact					
Name:					Relat	tionship:
Address:					Phon	ne:
If patient is a child, parent's name:					Phon	ne:
Insurance						
Primary:			Second	dary:		
			Subscri	Subscriber name:		
Date of birth:			Date of	f birth:		
ID#:	Grou	Jp#:	ID#:		Gr	oup#:
I authorize Redwood process insurance o	d Family Practice laims and assign t of my financial	e to provide payments obligation.	my insurance com to Redwood Family A photocopy of thi	npanies with all / Practice all of	informat	all treatment provided. tion necessary to rance benefits due to considered as a valid
Signature					Date	





# **Health History**

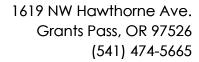
Name:			Date:		
Date of Birth:	Referred by:				
Please list other physician/pi	rovider:				
Social History					
Do you use tobacco:	☐ Yes ☐ No Averd	age amount (daily, weekly	/, monthly):		
Do drink alcohol:			/, monthly):		
Exercise: None	☐ Moderate ☐ Do	ily Heavy			
Women Only					
First menstrual cycle (ag	e):	Present form of birth c	ontrol:		
Date of last menstrual cy	ycle: # of pre	egnancies: Full-te	rm: Live births:		
Men Only					
•	am:	Date of last PSA test:_			
Past Medical History (ch	□ Fractures	□ Vidnov Stones	☐ Rotator Cuff Injury		
□ Anemia	Genetic Spinal Disorder	☐ Kidney Stones ☐ Liver Disease	Sciatica		
☐ Anorexia/Bulimia	Gout	☐ Migraine Headaches			
☐ Arthritis	☐ Headaches	☐ Multiple Sclerosis			
□ 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			
☐ Diabetes	☐ High Blood Pressure	☐ Prostate Problems			
☐ Emphysema	☐ High Cholesterol	☐ Prosthesis			
☐ Fainting	☐ Joint Stiffness	☐ Psoriatic Arthritis			
☐ Fibromyalgia	☐ Kidney Disease	Rheumatoid Arthritis			
Date of last colonoscop	y:	Date of last Dexa Scan:			
Diabetic Patients					
Date of last foot exam:_		Date of last eye exam	:		
Date of last A1c:		Date of last cholester	Date of last cholesterol panel:		



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# **Health History** (continued)

Name:			Date of Birth:_	Do	ate:
Previous Surgeri	es				
Туре		Year	Surgeon		City
Family History					
If living:					
	Health:				
Mother Age:	Health:				
If deceased:					
	Cause:				
Mother Age:	Cause:				
# of your childre	en: # living:_	# deced	ased:		
Ages of each o	f your children:				
Serious illnesses	of children:				
	<b>History</b> (Please chea				naternal or paternal.)
☐ Coronary artery disease		☐ Diabetes Ty	rpe I	☐ Heart rhythm	
☐ Diabetes Type	;	☐ Heart infec	tions/Inflammation	$\square$ Hypothyroidis	m
☐ Heart malform	nations	☐ Heart musc	le disorders	☐ High blood pr	ressure
☐ Psychiatric co	ndition	☐ Cancer (type	oe/location):		





## Medication

eferred pharmacy:			
lergies & Reactions (plea	ase include medications	, foods, latex, dye, e	etc.)
rrent Medication (list all r	nedications, including pr	escriptions, vitamins,	over-the-counter, herbs & suppleme
Medication	Dose	Frequency	Reason for taking
			_
			_
			_
			_
			_



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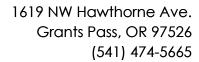
## **HIPAA LAWS POLICY & PROCEDURES**

I have had a chance to review and have been offered a copy of the HIPP	A Laws policies and Procedures.
Signature	Date
DISCLOSURE OF FEES AND PAYMENT POLICY Current Medication	n
I understand that all fees are based upon individual services rendered, and mare the doctor's specific recommendations. I also understand there is <b>one fee sche</b> e office. There is a 30% discount if you pay in full at time of service. If I desire, a correct All fees are subject to change without notice.	dule for all services rendered in this
I understand If I have extenuating circumstances, I can speak with the office maccount; which I will be given and application and if I qualify, I will receive a reaspecifically geared to my financial income.	
I Authorize Redwood Family Practice to receive direct payment from my insurar due on my account. I understand that I am responsible for insurance deductible bill not paid for by the insurance company due and payable on the day the se signature, below, to be kept on file and used as "my signature on file" to process authorize the release of medical or other information necessary to process all in	es, co-pays and any portion of the rvices are rendered. I authorize My ss all insurance claim submissions. I also
I hereby assign all medical benefits to which I am entitled to Redwood Family Premployees to sign for me on the back of any draft or check which they received insurance company, whether pursuant to medical payments coverage or health have an outstanding balance with them. Said amount shall be credited against outstanding balance accordingly. A photocopy of this assignment shall be contoriginal. I also authorize the release of any information pertinent to my case to attorney involved in this case.	th insurance coverage, as long as I t my account and shall reduce my sidered as effective and valid as the
I fully understand and agree to the above terms and acknowledge that I am ul monies owed to Redwood Family Practice regardless of the outcomes of any company. Should I receive any payment(s) or settlements for services rendered Family Practice within 5 days, or be immediately responsible for the entire amount	ourt case or denials by an insurance , I will forward those on to Redwood
Signature	 Date



# Consent to Release Protected Health Information to Friends or Family Members

Patient Name:	Date of Birth:		
I request Redwood Family Practice to re	elease protected healthcare information to:		
Name:	Relationship:		
Name:	Relationship:		
Name:	Relationship:		
This request and authorization applies to	):		
$\square$ All healthcare information (Medic	cal and Billing)		
$\square$ Healthcare information relating to	the following treatment, condition, or dates:		
☐ Ofher:			
I understand that this designation applie	es only to Redwood Family Practice.		
Signature	Date		
Revoccation/Termination			
I request to revoke/terminate the design	nation made above.		
Signature			





#### Release of Healthcare Information

Patient Name:					Date of Birth:
Address:				P	hone:
Released from:			Released to:		
Facility Name:			Facility Name:		
Address:					
City/State/Zip:					
Phone:	Fax #:		Phone:		Fax #:
Purpose of release:	$\square$ Transfer of Care	□R€	eferral/Consultation	□Pe	rsonal
records exist.	es below, I specifically au			owing me	edical records, if such
	ds (limited to 2 years unle	ess otner	•	ala. a .a. h	
Hospital			Emergency and		care records
Physical Therapy			Billing Statemer		
Laboratory/and o			Other:		
Diagnostic imagir	•	:4:			
nealineare relatir	g to the following cond	IIION OF II	realment dates		
I understand and agr space next to the typ	ee that the information e of information.	below w	rill be disclosed if I <b>pla</b>	ce my ini	itials in the applicable
HIV/AIDS testing/t	reatment		Mental Health :	specific v	visits
Genetic Testing			Drug/Alcohol s	pecific vi	sit
that I may revoke this revoked earlier, this a may refuse to sign this payment, enrollment under this authorization care provider or healuse disclosed and no lefrom disclosing my he	or eligibility for benefits.  on. I also understand the th plan covered by fede onger be protected by alth information under o person(s) I am authorizing	ne giving 80 days my refus I may in: at, if the peral privo these re other app	written notice to Rec from the date of significal to sign will not affe spect or copy any info person or entity receivacy regulations, the in- gulations. However, the plicable state or fede	lwood Formation wing this in formation formation formation for mation and the recipies all laws of the recipies all laws	amily Practice. Unless on. I understand that I willity to obtain treatment, to be used or disclosed information is not a health in described above may
This authorization will	expire 90 days after sign	ing.			
Signature					Date
 Print Name or Legal Rep	presentative (if applicable)				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.

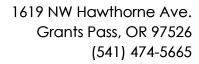
A failure to present at the time of a scheduled appointment will be recorded in our schedule as a "no show". The first time there is "no show", you will be sent a letter alerting you to the fact that you have failed to show up for an appointment and did not cancel the appointment. If you have three "no 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".





### **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