NORTHWEST
Family Practice

1600 NW 6th Street, North Suite
Grants Pass, OR 97526
Phone: (541) 916-5500
Fax: (541) 916-5010
NorthwestFamilyPractice.com

Patient Registration

Please Print Clearly

First & Last Name:_____ Maiden Name:_____

Date of Birth:_____ Gender: Male_____ Female_____ SS#:_____

Mailing Address:_____

Physical Address:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____ Preferred Pharmacy:_____

Please mark which methods of contact is your preferred contact for appointment reminders?

☐ Home phone ☐ Cell phone ☐ Email ☐ Decline to have reminders

If Patient is a Minor

Father's Name:_____ DOB:_____ Phone:_____

Address:_____

Mother's Name:_____ DOB:_____ Phone _____

Address:_____

Government regulations require us to ask the following question (please check)

☐ Patient Declined

Race:

☐ American Indian or Alaska Native ☐ Asian ☐ African American

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Decline to answer

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Emergency Contact

Name:_____ Phone:_____ Relationship:_____

Guarantor Information

Name:_____ Phone:_____ Relationship:_____

Address:_____

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Insurance Information

Primary Insurance

Insurance Company:_____ Policy #:_____

Claims Address:_____ Group #:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Relationship to Patient:_____ SS#:_____

Secondary Insurance

Insurance Company:_____ Policy #:_____

Claims Address:_____ Group #:_____

Policy Holder Name:_____ Policy Holder DOB:_____

Relationship to Patient:_____ SS#:_____

Consent for Medical Treatment

With the signature below, I authorize NorthWest Family Practice to perform the medical treatment deemed necessary by the medical provider(s) and their assistants. I also authorize NorthWest Family Practice to obtain all medical and prescription history through the electronic medical records system in place. I understand my health information may include information both created and received by the practice, may be in the form of written, electronic records, or spoken words. This may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

_____ _____

Signature (Patient/Parent/Legal Guardian) Date

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Pediatric Health History

Name _____ Date of birth _____ Date _____

Parent info: Father _____ DOB _____ Mother _____ DOB _____

Street address _____ City _____ State _____ Zip _____

Past Surgical History

List all surgeries (include date or age when surgery was done):

Date/Age	Surgery

Past Medical History

Circle below if child has had any of the following medical problems:

Allergies/Hay Fever	Meningitis	Childhood illnesses:	Other illnesses:
Epilepsy	Asthma	Measles (German/10 day)	
Anemia	Heart Murmur	Mumps	
Scoliosis	Eczema	Chicken Pox	
Diabetes	Hives	Whooping Cough	

List all medications, vitamins, supplements, over the counter medications (with dosage):

☐ Does not take medications.

Name of Medication	Dosage

Vaccinations (date of last):

Please bring a copy of the child's vaccination sheet

Tetanus/Tdap _____ Flu _____ Pneumonia _____

Allergies:

Medications	Reactions	Environment or food	Reactions

Social History:

Lives with both parents _____ Who else lives in the child's household _____

Places child has lived _____ What school does the child attend _____

Religious preference _____ Active _____ Inactive _____

Lifestyle:

Has child ever had a drinking or drug problem _____

How frequently does child consume alcohol _____ Last drink _____

Are there smokers in the house _____

Favorite recreations _____

Is child involved in sports _____ Which sports _____

How much time does child spend on TV _____ Video games _____ Computer _____

Family Medical History:

	Medical problems	Age	Age at death	Cause of death
Father:				
Mother:				
Other:				
Other:				

Circle diseases that any blood relatives have:	Which relative:
Cancer	
Diabetes	
High Blood Pressure	
Heart Problems	
Stroke	

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Appointment Cancellation and No-Show Policy

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- If you are a new patient and fail to show for your **first** appointment, we will not reschedule you.
- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24-hour notice** will be considered a NO SHOW and charged a **$25.00** fee.
- Any patient who fails to show or cancel/reschedule an appointment and has not contacted our office with **at least 24-hour notice** a second time will be charged a **$50.00** fee.
- If a third No Show or cancellation/reschedule with no **24-hour notice** should occur the patient may be **dismissed** from our practice.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- If you are late for an appointment you may have to reschedule your appointment. **Please be 15 minutes early for your appointment** so we can take care of administration tasks. **If you do not arrive 10 minutes before your appointment, you will be rescheduled**.
- **As a courtesy, when time allows, we make reminder calls for appointments.**

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office immediately. Our provider will be notified and we might be able to waive the No Show fee. You can leave a message on our answering machine 24 hours a day, 7 days a week.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Patient/Parent/Legal Guardian)	Relationship to Patient (self, parent, etc.)
Print Name (Patient/Parent/Legal Guardian	Date

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Acknowledgment of Receipt of Notice of Privacy Practices

I,_____(print patient name), acknowledge and agree that I have received a copy of NorthWest Family Practice's Notice of Privacy Practices.

Patient signature_____Date_____

Patient legal representative signature_____Date_____

Print name of legal representative_____

Relationship to patient_____

FOR CLINIC USE ONLY

NorthWest Family Practice made the following good faith efforts to obtain the above referenced individual's written acknowledgment of receipt of the Notice of Privacy Practices.

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

_____ Date_____

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Office and Financial Policies

Item #	Policy
1	**Prescription refills:** You are responsible to know when your medications must be refilled and to notify the office at least 48 hours before running out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours, or phone call refill requests.
2	**Information:** You are responsible for providing current information such as: name, address, cellular or other phone number, email address, and insurance information. Social Security number, driver's license, or picture identification must be provided at the time of registration or as requested by the practice at any time.
3	**Financial responsibility:** You accept financial responsibility for all charges for services rendered to you. If you are the parent or guardian accompanying the patient, you assume this liability. The office will not be involved in mediating financial arrangements between parents or guardians and are not a party in any divorce decree.
4	**Payment methods:** We accept cash, check, MasterCard, and Visa. Checks will be processed electronically unless otherwise stated. In the future, we may ask to keep your credit card number on file with your consent.
5	**Appointments:** Minors under age 15 must be accompanied by a parent or guardian to be seen unless special arrangements have been made with the office. We require a minimum of 24 hours (or the Thursday before a Monday appointment) notice of cancellation as a courtesy to other patients seeking services. A pattern of missed appointments may result in discharge from the practice.
6	**Form fees:** Our practice charges $25 for additional paperwork outside of the completion of the medical records. Many times we need to see patients to make diagnosis prior to filling out paperwork for medical accuracy. These appointments are subject to a charge.
7	**Medical records:** The medical chart is the property of the practice. However, a CD of your pertinent medical information is available upon request and is subject to a $30 fee. Records will be made available within 30 days of your request.
8	**Insurance co-payments, deductibles, and coinsurance:** Insurance companies do not always pay fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. Deductibles, co-insurance, or non-covered services are to be paid in a timely fashion according to office policies. **Copays are due at the time of your appointment** and we are obligated to collect per our contract with your insurance. If they are not paid within 24 hours after the appointment time a $10 charge will be assessed. If requested, and as a condition of service, you agree to sign an "advanced beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.
9	**Usual and customary:** Some insurance plans may indicate that our fees are above "usual and customary." As a result your plan may reduce our fee to an "allowed amount" before calculating payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we are specifically contracted with the carrier, it is expected that you will be liable for any fees.
10	**Slow insurance response:** You agree that if your insurance company takes more than 60 days to respond to your insurance claim, we shall consider the charges your financial responsibility and it will be your responsibility to seek reimbursement from your insurance company.
11	**Statement policy:** Patient statements are mailed every 28 days. Payments are due by the statement due date. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such a delay can take months. You understand that such a delay does not alter our policy of patient financial responsibility and you will be liable for all service fees. An interest charge of 1.5% per month will be assessed on balances 90 days or older as allowed by Oregon law.
12	**Collection and bank fees:** Accounts more than 90 days old are subject to transfer to an outside collection agency unless payment arrangements have been made through the billing department. Fees may be assessed by the collection agency and by banks for checks that do not clear. A $35 fee will be assessed by the office for any returned checks.
13	**Patient discharge:** The practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with a treatment plan(s) as outlined by your practitioner, repeated missed appointments, and failure to comply with a medication contract.
14	**Insurance claims:** If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignment" of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

I have read and understand all the terms of this policy. By signing below, I attest that I fully understand each item and agree to the terms above.

Signature_____ Date_____

Patient name _____

Document updated 02.01.23

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Consent to Release Protected Health Information

Patient Name_____Date of Birth_____

Consent

I request NorthWest Family Practice Clinic to release protected healthcare information to:

Name_____

Relationship to Patient_____Phone #_____

Name_____

Relationship to Patient_____Phone #_____

Name_____

Relationship to Patient_____Phone #_____

This request and authorization applies to: (please check below)

☐ 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 NorthWest Family Practice Clinic.

Patient Signature_____ Date Signed_____

Revocation/Termination

I request to revoke/terminate the designation made above.

Patient Signature_____ Date Signed_____

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Authorization to Use and Disclose Health Information

I hereby authorize (previous healthcare provider):

Name of disclosing party

Address

City, State Zip

To disclose to:

Name of Recipient

Address

City, State Zip

Records and information pertaining to:

Patient name (list other names used) SS# Date of Birth

Address Phone number

For the purpose of: Transfer of care/Continuity of Care

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the above date of signature unless a different date is specified here_____ (date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box, initial to specify which type of information is to be disclosed, and then sign and date.

- ☐ Medical information _____ (initials)
- ☐ Psychiatric information _____ (initials)
- ☐ Drug/Alcohol Information _____ (initials)
- ☐ Results of HIV Test _____ (initials)
- ☐ Genetic Records _____ (initials)

Signature:_____ Date:_____

A copy of this authorization is as valid as the original

For NorthWest Family Practice Use Only	Date faxed:	Date received: