147 S 52nd Place | Springfield, OR 97478 | Phone: (541) 746-1166 | Fax: (541) 393-1607

Stephan Ames, MD * Kathleen Jackson, MD * Michelle Kaplan, MD

Patient Name: _____

Appointment Date: _____

Appointment Time: _____

Scheduled Physician: □ **Dr. Ames** □ **Dr. Kaplan** □ **Dr. Jackson**

Welcome to Thurston Medical Clinic

We want to thank you for choosing Thurston Medical Clinic as your partner in healthcare. We realize that there are many choices available and are pleased that you have chosen to place your trust in us. We value each and every patient and hope that your first experience with our office was a positive one. Please let us know if there is anything that we could have done better, either now or in the future.

We look forward to building a relationship of trust and support which can grow over time. Through good communication and education our hope is to become your healthcare partner and give you the tools to make informed decisions about your healthcare.

Our two locations have adjacent parking lots which can at times become full. There is street parking available within close proximity of both offices, and we will reimburse any meter costs. Just notify the front staff when checking in.

Enclosed you will find paperwork we need you to complete and bring with you for your appointment. If this is not completed when you come in it may delay your appointment time. Please arrive 30 minutes prior to your appointment time for paperwork and insurance processing at check in as part of the patient registration process.

Today's Date: _____

PRAXIS
MEDICAL GROUP

PATIENT INFORMATION

Date of Birth: _____ Age: _____ Sex: ____ Gender Identity: _____Sexual Orientation: _____

First Name: _____ MI: ___ Last Name: _____ SSN#:_____

Marital Status: S___ M___ D___ W___ Email Address: _____

Race: _____ Ethnicity (Circle One): Hispanic/Non-Hispanic Primary Language: _____

Street Address: _____ Mailing Address (If Different):_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work phone:_____ Employer/Occupation:_____

Emergency Contact: _____ Relationship: _____ Phone: _____

ACCOUNT RESPONSIBILITY (If different than above)

Who is responsible for this account? _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____

Cell Phone: _____ Home Phone: _____ Date of Birth: _____SSN#: _____

MEDICAL INSURANCE

Name of Primary Insurance Company: _____

Subscriber Name: _____ Group # _____

Member ID: _____ Subscriber Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Group # _____ Member ID: _____

Subscriber Date of Birth: _____ Medicare ID (If on Medicare): _____

CASH PAY POLICY

Patients without medical insurance are required to pay $125.00 at the time of service to see a primary care provider, and $175.00 at the time of service to see a specialist or have imaging performed. Please note that your balance may be more than the above stated amounts, and will be determined based on actual services rendered during your office visit. Any patient without medical insurance who is paying in cash for an office visit will receive 20% off of their end balance.

By signing below you state that you have read and understand the above cash pay policy.

Patient/Guardian Signature: _____

CLINIC BILLING AND EXPECTATIONS

Please sign below to indicate you have read and understand the following:

1. **Responsibility for payment of your account remains with you at all times**; and although you may have a pending insurance claim, we will require you to pay regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if your claim is related to OREGON WORKERS COMP, AUTO RELATED, OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

2. Copays and other estimated out of pocket amounts due are to be collected at the time of service.

3. You will receive a monthly statement showing itemized charges and the total amount due on your account. Payment in full is required within 30 days of the statement date, unless arrangements are made with our billing office.

4. If you need to set up a payment plan, our Praxis Main billing phone number is (877)708-1119. For Oak Street Medical billing please call (844)379-9930, and for Pendleton Family Medicine billing please call (844)379-9931.

5. A $45.00 fee will be charged to your account if you do not cancel your appointment 24 hours in advance. After three no show appointments, you will be subject to discharge from Praxis Medical Group.

6. There is a $35.00 fee for all returned checks and for stop payments.

7. No credit will be extended to patients having a past due account, or to patients who have been referred to a collections agency. If your account has been referred to a collections agency two times, you will be discharged from Praxis Medical Group.

8. If you arrive more than seven minutes late to an appointment, you may be asked to reschedule.

9. Praxis Medical Group requires 2 business days to respond to all medication refill requests. Medications will not be refilled after clinic hours. Please contact your pharmacy to initiate refill requests.

CONSENT FOR TREATMENT

By signing below, I am requesting Praxis Medical Group to provide health care related treatment and consultation to the below named patient, and that I may refuse treatment or services at any time. I understand Praxis Medical Group does not guarantee any outcome for any services or treatments, either stated or implied.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

Acknowledgment
Privacy Policy Offered

My health information may be created or reviewed by Praxis Medical Group and may be in the form of written or electronic records, or spoken words. My health records may include information on my health history, health status, test results, diagnoses, treatments, procedure, prescriptions and similar types of related health information.

I understand that I have the right to receive and review a written description of how Praxis Medical Group will handle my health information. This written description is known as a **Notice of Privacy Practices**. This notice describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Praxis Medical Group and my right regarding my health information. I may obtain a copy of the **Notice of Privacy Practices** at the reception desk or view it on the clinic website.

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 summary of the most current version of the Praxis Medical Group's **Notice of Privacy Practices** in effect will be posted in the waiting/reception area and on the clinic website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to receive a copy of Praxis Medical Group's Notice of Privacy Practices.
Notice of Privacy Practices copies are available at the reception desk.

Patient Confidential Communication

The Health Insurance Portability and Accountability Act (HIPAA) gives you the right to request that we communicate financial and/or medical information to you in confidence by a particular method or certain locations. In order to protect the privacy and confidentiality of your information, please complete the following.

I give permission to Praxis Medical Group to leave messages regarding appointments, billing and medical information on any of the following phone numbers: _____

I give permission to Praxis Medical Group to share health and billing information with:

_____

Relationship: _____

This release will be revoked by written permission only. I understand that I must send a written request to Praxis Medical Group in order to revoke this request.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

FORMULARY BENEFITS MANAGEMENT (PBM) CONSENT FORM

Formulary Benefit data are maintained for health insurance providers by organizations known as Pharmacy Benefit Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for Praxis Medical Group to access my pharmacy benefits data electronically through RxHub. This consent will enable Praxis Medical Group to:

- Determine the pharmacy benefits and drug copays for a patient's health plan
- Check whether a prescribed medication is covered (in formulary) under a patient's plan
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies
- Download a histories list of all medications prescribed for a patient by any provider

In summary, we ask your permission to obtain formulary information and information about other prescriptions by other providers using RxHub. This consent will be in place until revoked in writing.
I give permission for Rx History consent: (yes/no) _____

Care Management Services Financial Agreement

With the transformation of health care across the country, there were new government billing guidelines established in 2015 for services identified as "Care Management". These services are non-face to face and include but are not limited to: follow ups for emergency room visits, inpatient hospitalizations, as well as coordination of care for ongoing chronic conditions. Examples: Diabetes, Hypertension.

These services are rendered by multiple means, to include but are not limited to: telephone and/or email contact, directly with client or their designated health contact, other health care professionals, as well as verbal and written reports.

These services are billable to your insurance plan; their payment processing will depend on your individual plan coverage. By signing below you agree to allow us to provide these services for you.

I give permission for care management services: (yes/no) _____

By signing below you state that you have read and understand the above statements regarding PBM consent and Care Management Services financial agreement.

Patient Name (Please Print):_____Date of Birth: _____

Signature (Patient/Guardian) : _____Date:_____

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AUTHORIZATION TO DISCUSS HEALTH INFORMATION (verbal communication only)

Patient Name: _____ Patient DOB:_____

Identification password: _____ (the authorized person below will need to know this password)
Optional

I authorize Thurston Medical Clinic to discuss the areas I have identified below with the individual listed (Friends and Family members). I acknowledge with the signing of this form the medical data to be released may include information that is specific to HIV/AIDs, drug and or alcohol and / or psychiatric treatment if I have initialed those items separately.

If you choose to restrict disclosure to someone you previously authorized, please ask for our "Restriction form".

PLEASE PRINT (use black ink)

_____ _____
Name and phone # of person authorized (One person per line) **Relationship to you**

☐ Unlimited access (to all information listed below)
- ☐ Financial information
- ☐ Discuss Treatment
- ☐ Appointment scheduling/cancellation
- ☐ Sexually transmitted diseases

MUST BE INITIALED TO BE INCLUDED:

_____**Alcohol/Drug Treatment**
_____**Psychiatric Information**
_____**HIV/AIDS information**
_____**Genetic information**

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosure already made with your permission. To revoke this Authorization, please send a written statement to attention of Privacy Officer, 147 S 52nd Place Springfield, OR 97478. The notice should include the full name and relationship of the person you are revoking privileges from, along with your full name, date of birth, current date and signature.

The information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law.

_____ _____
Signature *Date*

This authorization will remain in effect unless a stop date is identified or a written notice to revoke is received. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640.

Stop Date:

NOTE-THIS IS NOT A RECORDS RELEASE FORM

Patient History, 0-17 Years

Immunizations
Please Supply Records To Our Office

Patient Name (Print) _____ DOB _____

Both Parents / Guardian Names (Print) _____

Family History

M = Mother F = Father GP = Grandparents S = Sibling

Description	M	F	GP	S	Age of Onset / Comments
Diabetes					
Migraines					
Asthma					
Allergies					
Depression / Mental Illness					
Cardiovascular Disease					
Hypertension					
Thyroid Problems					
Blood Clotting Disorder					
Cancer					

Personal History

Birth Weight: _____Pounds _____Ounces

Date of last menstrual period (if pertinent): _____

Prenatal (Before birth) or Birth Complications: ❑ Yes ❑ No

Explain _____

Asthma ❑ Yes ❑ No Fainting ❑ Yes ❑ No Frequent Illnesses ❑ Yes ❑No

Describe _____

Hospitalizations, Cause & Date(s) _____

Other Health Problems _____

Surgeries, Type & Date(s) _____

Social History

Who do you live with ❑ Mother ❑ Father ❑ Blended Family ❑ Self ❑ Other: _____ Brother's Age(s): _____ Sister's Age(s): _____

Smoking at Home ❑ Yes ❑ No Attend Daycare / After School Care ❑ Yes ❑ No School Grade: _____

History of Traumatic Event ❑ Yes ❑ No Time Spent Watching TV Daily : _____ Hours Time Spent on Computer/Video Games Daily: _____ Hours

Car Seat Used ❑ Yes ❑ No Seatbelt Used ❑ Yes ❑ No Helmet Used While Cycling/Motorcycling ❑ Yes ❑ No

Smoke ❑ Yes ❑ No Recreational Drugs Used ❑ Yes ❑ No Drink Alcohol ❑ Yes ❑ No Fluoride Used ❑ Yes ❑ No

Guns Kept in Home ❑ Yes ❑ No If Yes, Are They Locked Up ❑ Yes ❑ No Sexually Active ❑ Yes ❑ No

Dietary Concerns ❑ Yes ❑ No Please Describe: _____

Review of Systems

Please check all problems which are recurring chronic conditions. Explain Below.

✓	Systemic	✓	Nervous System	✓	Gastrointestinal	✓	Musculoskeletal
	Fever		Dizzy		Abdominal Pain		Joint Pain
	Chills		Tremors		Constipation		Deformities
	Headache		Headaches		Diarrhea		History of Fractures
	Stiff Neck		Numbness		Vomiting		History of Trauma
	Swollen Glands		Seizures		Problem Eating	✓	**Genitourinary**
✓	**Eyes**	✓	**Endocrine**	✓	**Cardiac / Pulmonary**		Painful Urination
	Vision Changes		Excessive Thirst		Shortness of Breath		Problems with Urination
	Corrective Lenses		Weight Loss / Grain		Wheezing		Vaginal Discharge
	Cataracts		Menstrual Problems		Coughing	✓	**Psychological**
	Pain	✓	**Skin**	✓	**Ears / Nose / Throat**		Low Mood
✓	**Allergies**		Rash		Sore Throat		Hyperactive
	Hay Fever		Itching		Nasal Discharge		Behavior Problem
	Medications				Ear Pain		Considered Suicide
	Others						Developmental Delay

Please Explain: _____

Patient / Guardian Signature _____ Date _____

Provider's Signature _____ Date _____

Records Release

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Authorization of Disclosure of Protected Health Information - Incoming

FOR FORM TO BE VALID, ALL SECTIONS MUST BE COMPLETED

I authorize (physician, office, or person):_____

Address: _____

Phone: _____ Fax#_____

To release my medical information to **Thurston Medical Clinic.**

The specific medical records to be released is (please initial):

_____ All Medical Records for the past 2 years including chart notes, labs and imaging reports. I understand that medical records may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, or mental health concerns, discussion of HIV testing**. I consent to have the above information released.

OR

_____Specific Medical Records from _____ to _____ or _____ most recent.
Please check medical records requested:

___Chart Notes ___Lab/Pathology Reports ___Imaging/Diagnostic Reports ___Immunization Records

Specially Protected Information (please initial):

_____I consent to disclosure of genetic testing information.
_____I consent to disclosure of alcohol and drug treatment.
_____I consent to disclosure of mental health treatment.
_____I consent to disclosure of my HIV/AIDS information.

The purpose of release for HIV/AIDS test result/record is for: _____.

HIV test results may be released from _____ to _____.

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 have copies of 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 redisclosed and no longer 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 remain in effect for one year from the date of signature unless a stop date is identified. To revoke authorization prior to an expiration date or stop date, a written notice to revoke is required. If the patient is a minor, the authorization will expire once the patient reaches the age of consent, which is age 15 per OR 109.640. [Insert applicable date or event of expiration]_____.

Patient Name_____ **Date of Birth:** _____

_____ _____
Signature of Individual or Authorized Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual