PHONE
503.972.0235
TOLL FREE
1.866.972.0235
WEBSITE
WWW.OREGONIH.COM

OREGON INTEGRATED HEALTH

PORTLAND LOCATION
1427A NW FLANDERS ST
PORTLAND OR 97209

EUGENE LOCATION
1029 RIVER ROAD
EUGENE OR 97404

SALEM LOCATION
1535 LIBERTY ST SE
SALEM OR 97302

FLORENCE LOCATION
1441 7TH ST. SUITE B
FLORENCE OR 97439

Thank you for choosing Oregon Integrated Health as your Integrative Primary Care Clinic!

- Please arrive **10 minutes prior** to your appointment time with your paperwork already completed. This will help our staff to have you ready to see your physician on time.
- New patients must arrive to their first patient appointment **10 MINUTES prior** to complete paperwork or have completed paperwork prior to appointment. You may be rescheduled without completed paperwork.
- Our office will contact your insurance company to verify coverage and benefits. Please verify your coverage and that you are active on your health plan prior to your appointment. Co-payments, Co-insurance, Lab Payments and Deductible amounts are payable at the time of service. We accept,, Visa, MasterCard. Please note Oregon Integrated Health does not accept cash or checks.
- Late Appointments are considered if you arrive 10 minutes or more past your appointment. You will be asked to reschedule. We strive to see every patient as close to their appointment time as possible. We ask that you please be courteous of your provider's valuable time and attention.
- OIH will contact you via phone, text message and email if applicable. If you have a preference please notify the front desk or schedulers.

Appointment Policy

Our office requires 24 hour notice if an appointment cannot be kept or needs to be cancelled. **You can text our main office number #CANCEL between 8am and 5pm**. If before 8am or after 5pm, please leave a message on our voicemail. We make every effort to provide reminder calls, text messages and emails 48hr and 24hr before your scheduled appointment.

All "No Show" appointments are tracked within the patient's medical record. There is a $50.00 fee attached to all "No Show" appointments subsequent to the first offense. Patient's will receive a text message notifying of missed daily appointments. If you have pending future appointments these will be cancelled unless you confirm that you will be attending these appointments. Each patient is provided same day opportunity to reschedule. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care. New patients that No Show to their first 2 appointments are discharged from the practice.

Thank you, we look forward to meeting you soon.

Oregon Integrated Health

OREGON INTEGRATED HEALTH

Personal Information

First Name:	Middle:	Last Name:
Preferred Name:	Gender:	Date of Birth:
Age:	Preferred Phone Number:	Alternate Phone Number:
Email:		
Mailing Address:		
City:	State:	Zip:
Ethnicity:	Preferred Language:	Race(s):
OIH Primary Care Provider:	Preferred Pharmacy:	
Emergency Contact Name:	Emergency Contact Relationship to You:	Phone Number:

GUARANTOR - PERSON FINANCIALLY RESPONSIBLE FOR PATIENT ACCOUNT
ONLY COMPLETE IF YOU ARE NOT THE GUARANTOR

Patient Relationship to Guarantor: SPOUSE CHILD OTHER:

Guarantor Name:	Guarantor Phone:
Guarantor Date of Birth:	Guarantor Address if Different than Above:
Guarantor Address if Different than Above:	

Today's Date: _____

First/Last Name: _____

Date of Birth _____ Preferred Name: _____

OREGON INTEGRATED HEALTH

OREGON INTEGRATED HEALTH - ADULT Health History for NEW Patients

Your answers on this form will help your healthcare provider get an accurate history of your medical concerns and conditions for today's visits and future visits. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit: General Health Exam / Screening Physical

Physical Symptoms? Emotional Symptoms?

☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M ☐ Other:

Do you have an **Advanced Directive, Living Will, POLST ?** ☐ Yes ☐ No

Please list all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc

_____

_____

☐ I do not take any prescription medicines

Do you have any Allergies or Reactions to any Medicines or Shots?

_____

_____

☐ No I am not allergic to any medicines or Shots Other Known Allergies?

FAMILY HISTORY Have any of your **family members** ever had any of the following health problems?

Check all that apply	Alive	Passed Away	Diabetes	High Blood Pressure	Cancer	Heart Problems
Mother						
Father						
Sisters # sisters:_____						
Brothers # brothers:_____						

Other Significant Family History:

SOCIAL HISTORY

Do you drink alcohol?	☐ No	☐ Daily ☐ Weekly	☐ Previous Addiction?
Do you use drugs?	☐ No	☐ Yes Types of Drugs:	
Do you smoke cigarettes?	☐ No	Number of years:	Number of packs per day:

Do you have sex with ☐ Men ☐ Women ☐ Both ☐ I don't have sex

If you use birth control, what type do you use?

Special Diet or Restrictions? ☐ Vegan ☐ Vegetarian ☐ Gluten Free ☐ Other

Sleep: ☐ Good? ☐ Average? ☐ Poor?

Significant Stressors in your life?

How many days per week do you exercise?

PREVENTATIVE HEALTH

Are you up to date on Immunizations? ☐ Unsure		If Sexually Active - Last Date of STI Testing?	
Date of Colonoscopy/FIT Test?	Date of Bone Scan?	Date of Vision Screening?	
Female	Date of Last PAP Exam?	LMP?	Date of Mammogram?
Male	Self Testicular Exams?	Date of Prostate Exam?	

Please check the symptoms listed below that you : <u>Currently (C)</u> have or have had in the <u>Past (P)</u>

Symptoms	C	P	Symptoms	C	P	Symptoms	C	P	Symptoms	C	P
Fever	☐	☐	Breast Lumps	☐	☐	Falling	☐	☐	Problems urinating	☐	☐
Excessive Thirst	☐	☐	Chest Pain/ Pressure	☐	☐	Nausea or Vomiting	☐	☐	Urinary urgency	☐	☐
Unexplained Tiredness	☐	☐	Irregular Heart Beat	☐	☐	Bloody Stools	☐	☐	Testicular Pain	☐	☐
Easy Bruising or Bleeding	☐	☐	Wheezing/ Breathing Troubles	☐	☐	Diarrhea or Constipation	☐	☐	Vaginal Pain	☐	☐
Vision Loss	☐	☐	Rashes	☐	☐	Joint/Muscle Pain	☐	☐	Rectal Pain	☐	☐
Sore Throat	☐	☐	Changes in Moles	☐	☐	Back Pain	☐	☐	Difficulty concentrating	☐	☐
Runny Nose	☐	☐	New or Unusual Headaches	☐	☐	Seizures	☐	☐	Nervous or Anxiety	☐	☐
Hearing Loss	☐	☐	Weakness/ Numbness	☐	☐	Cold/Heat Intolerance	☐	☐	Depression	☐	☐

ADULT ORAL HEALTH - Services Provided by Oregon Integrated Health

Date of your last Oral Health Exam: Name of Dental Primary Care Provider:	Have you ever been told you need antibiotics/premedication before a dentist appointment? □ YES □ NO

Oregon Integrated Health is integrating Oral Health into our primary care clinic in Eugene as an additional preventative care service for adults, adolescents and children. Below is an example of services offered by our Expanded Practice Dental Hygienist. Our goal is to screen and then provide you information or coordinate appointments as necessary with your Dental Primary Care Provider.

Below are services offered to all patients - your consent is for appointments that you choose to make with the Expanded Practice Dental Hygienist. All services are reviewed and you may decline any service at anytime, Oral Health Services are provided for your convenience as an additional access to oral health.

Oral Health Screening - All Ages

Expanded Practice Hygienist will look in the mouth to check for changes in teeth that may indicate cavities or other oral health problems. Expanded Practice Hygienists teach patients appropriate oral hygiene strategies to maintain oral health and counsel patients about good nutrition and its impact on oral health
Risk: Decay or other problems could exist and get worse if not discovered.

Fluoride Varnish - All Ages

A temporary thin coating (also called varnish) put on the teeth to help protect from cavities. The coating is safe even if it is swallowed. It does not hurt or stain the teeth.
Risk: Allergy is not common.
Alternatives: Daily or weekly fluoride rinses, fluoride foam, or fluoride gels applied at your dentist's office.

Sealant - Coming Late Summer/Fall 2019 - Ages 6 - 12 YO

A dental sealant is a white coating put on the chewing surfaces of back teeth where cavities occur most often. Sealants make barriers on teeth that keep bacteria out and prevent cavities. They do not interfere with biting or chewing.
Risk: Sealants only protect the chewing surfaces. They can last for several years, but sometimes need to be replaced.
Alternative: Silver Fluoride. No sealants. Choosing not to use sealants could increase the chances you will develop decay in the chewing surfaces of the teeth.

Silver Fluoride - Coming Late Summer/Fall 2019 - All Ages

Fluoride with silver looks like water. It is painted on the teeth with a tiny brush and can heal early tooth decay. It goes on quickly, and does not hurt. If there are cavities in the mouth, silver fluoride can stop them from growing, and sometimes even heal them. Cavities that are stopped or healed with Silver Fluoride will turn dark brown or black. Teeth without cavities will not change color. Fillings may not be needed for cavities that are healed with Silver Fluoride.
Risk: If Silver Fluoride comes in contact with skin it will cause a small dark spot that will go away on its own in 1-2 weeks. If it comes into contact with existing white fillings it might stain.
Alternatives: No Silver Fluoride applied. This could leave harmful bacteria on your teeth and increase the chance of tooth decay. Use fluoride toothpaste regularly and have fluoride varnish and sealants applied at your dental office. Your oral health provider at OIH will have pictures of how Silver Fluoride looks on teeth.

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HIPAA - CONSENT AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my protected health information for all practitioners of Oregon Integrated Health, (OIH), for the purposes of treatment, coordination of care, payment and healthcare operations, or as otherwise required by law.

I acknowledge that I have a right to review or receive a printed copy of the Notice of Privacy Practices provided by Oregon Integrated Health prior to signing this consent. The Notice of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.

I have the right to request restrictions to the usage and disclosure of my protected health information.

I have the right to request an alternative to the standard method of communication of my protected health information.

I understand that if I wish to revoke this consent at any time I will do so in writing and submit to the address listed below. I understand that Oregon Integrated Health may honor these requests, they are not required by law to do so. I also understand that revocations will be honored as of the date they are received by Oregon Integrated Health at the following address:

OIH Administration Office: 2459 SE Tualatin Valley Hwy #416 Hillsboro, OR 97123

I understand that if I have any questions or complaints I may submit them in writing to the address above or contact Oregon Integrated Health by phone at 503.972.0235 ext 2108 or office@oregonih.com.

I am aware that Oregon Integrated Health reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Oregon Integrated Health will make available a revised Notice of Privacy Practice for my review.

FINANCIAL POLICY

- **Payment is due at the time of service**: ALL SERVICES NOT COVERED BY YOUR HEALTH, DENTAL, MVA OR WORKERS COMPENSATION INSURANCE ARE PATIENT/GUARANTOR RESPONSIBILITY. Credit card payments will be accepted at time of visit, over the phone or payments may be made online. All services, deductibles, co-pays, co-insurances, outstanding balances, supplies, lab work, tests as well as any additional expenses incurred in connection to your health not covered by your insurance is your responsibility. If requested, a copy of services provided will be given to you.
- **You agree that all information you have provided on all forms are true to the best of your knowledge.** If incorrect information is provided or you do not disclose full insurance information payment for all services rendered will be your responsibility. All information written is a patient/guarantor full responsibility, OIH is not responsible for information provided to us that is illegible or may be misinterpreted.

- **Office Services**: If you have health/dental insurance, **Oregon Integrated Health** will assist with verifying eligibility for office visits pertaining to your scheduled appointment at our clinic. The verification of your benefits, lab services, motor vehicle accident, or workers' compensation insurance is used to determine if there is coverage for services through your insurance carrier and is NOT a guarantee of payment by your insurance carrier. Your signature here designates that you understand you are fully responsible for being aware of any coverage exclusions and any payments. Contact your member services regarding your coverage information before your visit our clinic to ensure that you understand your coverage, costs for all services that you will receive at our clinic.
- **Co-Pays, Deductibles, and Co-Insurances:** Please note we only file for your insurance's share of services provided. The patient's share of co-pays, deductibles, and co-insurance are due at the time of service.
- **Secondary Insurances:** Secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment.
- **Lab Payments:** It is patient responsibility to verify your lab benefits with your insurance, please notify the front desk of specific lab requirements.
- **No-Show Appointments:** The following fees will apply for "no-show" appointments:
    - There is a $50.00 fee attached to all "No Show" appointments subsequent to the first offense.
    - After three (3) missed appointments, the practice may at its discretion choose to discontinue your care
    - New patients that No Show to their first 2 appointments are discharged from the practice.
- **Statements**: Statements are mailed out monthly. OIH will collect the balance prior to your next appointment.
- OIH reserves the right not to schedule you an appointment until a payment plan or payment in full has been placed on your account.
- Patients will be sent to collections after 4 missed payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical/dental and clinical benefits, to Oregon Integrated Health. I hereby authorize and direct my insurance carrier(s), including Medicaid, Medicare, private insurance and any other health/medical/dental plan, including motor vehicle and workers compensation to issue payments/check(s) directly to Oregon Integrated Health for all services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Oregon Integrated Health to: (1) release any information necessary to insurance carriers regarding my illness and/or treatments: (2) process insurance claims generated in the course of examination or treatment: and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested health services - which may include medical, oral health, mental/behavioral health and any other clinical service that I make an appointment with from Oregon Integrated Health. On behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

CONSENT OF TREATMENT

I will complete all information on health history and demographic forms accurately and verify this information is true to the best of my knowledge. I consent to all clinical/medical/oral health treatments from all providers at Oregon Integrated Health and authorize my insurance benefits be paid directly to the provider and/or Oregon Integrated Health. I understand that I am financially responsible for any balance per the financial policies of Oregon Integrated Health. I also authorize Oregon Integrated Health or insurance company to release any information required to process my claims.

COMMUNICATIONS

You acknowledge that communications with Oregon Integrated Health and/or the providers using email, SMS and phone and/or mobile devices such as; iPads, laptop computers are not guaranteed to be secure or confidential methods of communication. Oregon Integrated Health uses HIPAA compliant conduit applications. You acknowledge that all such communications may become a part of your medical record. Telemedicine visits are not recorded or stored. You are acknowledging and confirming your consent to receive such messaging to document your compliance with the Telephone Consumer Protection Act (TCPA). You authorize Oregon Integrated Health to communicate with you by e-mail or SMS regarding your "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations) using the e-mail address and phone number you provide to ClinicOps. By providing OIH with your e-mail address and phone number, you acknowledge that: although Oregon Integrated Health and the Provider will make reasonable efforts to keep e-mail and SMS communications confidential and secure, neither OIH nor the provider can assure or guarantee the confidentiality of e-mail or SMS communications; e-mail and SMS communications may be made a part of your permanent medical record; E-mail and SMS is not an appropriate means of communication regarding emergency or other time-sensitive issues or for inquiries regarding sensitive information. If you choose to opt out of email and/or SMS please notify the front desk.

My electronic signature certifies that I have read, understand and agree to the terms of Oregon Integrated Health, HIPAA Notice of Privacy Practices, Financial Policy, No Show Cancellation Policy, Assignment of Benefits, Authorization to Release Information and Consent to be Treated. I agree that all information I have provided is accurate and true to the best of my knowledge. **Date Signed**_____

Patient Signature (18 years or Older) _____ **Full Name**_____**DOB**_____

Guarantor Signature: I hereby acknowledge that I am financially responsible for payment of all services rendered to the above named patient that I am subject to all financial terms.

Guarantor Full Name: _____ **Signature** _____ **Date Signed**_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, your rights concerning your health information, and our legal duties. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect October 1, 2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices in the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, coordination of care, payment, and healthcare operations to *all* practitioners at Oregon Integrated Health.

Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

Coordination of Care: We may use and disclose your health information to to a physician or other healthcare provider providing treatment to you to ensure the safety of your care provided does not conflict or cause harm and is therapeutically effective.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, coordination of care, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Minors Under the Age of 18: The parent may have access to the medical records of the minor related to treatment when State or other applicable law requires or permits such parental access.

Behavioral, *Mental Health & Chemical Dependency:* We may disclose your health information to other providers at Oregon Integrated Health to ensure safe coordination or care and treatments.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

PATIENT RIGHTS *Access*: You have the right to get copies of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies.

Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that :

- We did not create
- Is not part of the health information that we maintain
- You would not be permitted to inspect and copy
- Is accurate and complete

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, and a limited number of special circumstances involving national security, correctional institutions and law enforcement. The list will also exclude any disclosures we have made based on your written authorization.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Electronic Notice: If you receive this notice on our web site or by e-mail, you are entitled to receive this notice in written form.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the U.S. Department of Health and Human Services. To file a complaint please contact us at the number or address listed on the top front page of this notice. You will not be penalized for filing a complaint.

Oregon Integrated Health Telemedicine Consent

I understand that my OIH healthcare primary care clinic wishes me to engage in a telemedicine consultation.

OIH has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by Medical Assistants at my location at the direction of the consulting health care provider.

I have had a direct conversation with my healthcare primary care provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

That I have read or had this form read and/or had this form explained to me;

That I have had the opportunity to ask questions about the information presented in this form and that any questions have been answered to my satisfaction.
That I fully understand its contents including the risks and benefits of the procedure(s).

Date of Birth: _____

Patient's/Parent/Guardian Signature _____

Todays Date :_____