

5311 N. Vancouver
Portland, OR 97217



Phone: (503) 281-0308
Fax: (503) 281-4691

Dear New Patient Parent of a 4-10 year old child:

Thank you for choosing Hands On Medicine as your child's primary care provider! We look forward to providing care for you and your family.

Enclosed you will find:

Demographic form: name, address, insurance information, etc. Please fill out to the best of your knowledge.

Child Health History form: knowing as much as possible about your child's Health History will help us tailor their health care to be as comprehensive as possible.

Release of Records form: if you have records from a previous primary care provider that may be of relevance, prior medical records, or if you would like a future copy of your child's records from Hands On Medicine for yourself, please fill out this form. Also, please bring any relevant medical records and all current medications in original bottles to your child's first appointment.

Policy Statement: a summary of Hands On Medicine's clinic policies. **Please be sure to read our policies and sign at the bottom.**

Privacy Policy: a summary of Hands On Medicine's privacy policy, including your rights regarding your child's Protected Health Information (PHI) and our responsibilities in safeguarding this information.

Please fill out these forms and bring them with you to your child's first appointment (to insure we have all the information ready for their appointment, please arrive 15-20 minutes early).

Please feel free to call at (503) 281-0308 with any questions, and we look forward to being your health care partner in the years to come!

Shelda Holmes, FNP
Hands On Medicine



In an effort to provide the best medical services, we have established the following policies.
Your signature below signifies your willingness and understanding to comply with our policies.

POLICY STATEMENT: PAYMENT POLICY _____ Initial

- You will be required to provide proof of insurance at every visit. In compliance with new Federal law, we will ask you for photo identification and may take your picture at your first office visit.
- It is impossible for our office staff to be aware of each insurance plan's specific requirements or to guarantee coverage by any individual plan. We will do our best to assist you, however it is ultimately your responsibility to verify that we are a member of your PPO or HMO network.
- Your plan may have limitations on the frequency of services performed or where the services may be performed. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements.
- As with any provider's office, any charges you incur at Hands On Medicine, which are not paid or adjusted by your insurance carrier, will be your sole responsibility. As a courtesy, we are glad to bill your insurance carrier on your behalf.
- If you do not have insurance or lose your insurance, we will be happy to provide care for you. However, you will be required to **pay in full** at the time of your office visit. We provide reduced rates for cash paying patients.
- If your deductible hasn't been met for the year, we may require you to pay in full at the time of your office visit. We will then bill your insurance and refund you any claims that are reimbursed.
- We accept cash and credit or debit card payments. **We do not accept checks**, except for balances sent in the mail. There is a \$50.00 bounced check fee in addition to fees charged by your financial institution.
- Payment is due within 30 days of receiving your bill, after which time your account will incur a \$20 a month charge. If your balance is not paid in full within 90 days your account will be sent to collections, at which point you will be charged an additional 35% of the balance you owe.
- Hands On Medicine is happy to continue providing care while you pay off this balance provided all office visits and other charges acquired from this day forward are paid in full at the time of service.

POLICY STATEMENT: PRESCRIPTION REFILL POLICY _____ Initial

- Please allow **3-5 business days for all prescription refills**. Ask your pharmacy to fax a refill request to the clinic at 503-281-4691 to speed up the process. If you use a mail order pharmacy, please allow 2 to 3 weeks.

POLICY STATEMENT: RECORDS _____ Initial

- We are happy to provide you a copy of your medical records gratis. However additional copies will require a charge in accordance with OAR 847-012-000.

POLICY STATEMENT: CHANGES IN DEMOGRAPHIC/INSURANCE INFORMATION _____ Initial

It is **your responsibility** to advise the clinic of any change in insurance coverage, or changes in name, address, or telephone number

Signature: _____ If Parent or Guardian, Name of Child: _____ Date: _____

POLICY STATEMENT: 24-HOUR CANCELLATION/NO-SHOW POLICY _____ Initial

- Our clinic policy requires a **24-hour cancellation notice** for all appointments. Your appointment time is reserved for you. If you do not show or give the clinic less than 24-hour notice, you will receive a letter and a bill in the mail. If you repeatedly neglect this policy, you will be dismissed as a patient.
- If you cannot make it to your scheduled appointment, please call to reschedule (you may leave a message after hours). This allows us to give your appointment time to another patient who needs to be seen on that day, and helps us find time for you when you need to be seen on short notice.
- Unlike most other clinics that double-book office visits, we do not double-book our appointments and reserve office visits 20-40 minutes in length. Therefore a 24-hour cancellation notice from you is vital to providing the longer appointments our patients require for comprehensive health care. There will be a \$50 charge for a No-Show or less than 24-hour cancellation notice.
- **This charge will not be paid by your insurance company.** This collection fee will be donated to N/NE Community Clinic or Josiah Hill Clinic.

POLICY STATEMENT: AFTER HOURS URGENT SERVICES (REACHING ON-CALL PROVIDER) _____ Initial

- We provide 24/7 on-call coverage. If you have an urgent matter that can't wait until business hours, you may reach an on-call provider by calling the clinic and following the prompts on the outgoing message.
- However you should be aware that many insurance companies provide 24-hour nursing lines intended for this purpose and therefore may not cover this service. If this is the case, you will be charged \$55.
- This service is **not** intended for non-urgent matters, making appointments, or prescription refill requests.

POLICY STATEMENT: MOTOR VEHICLE ACCIDENT CLAIMS _____ Initial

- We do accept claims for Motor Vehicle Accidents (MVA), however we do require a \$500 deposit prior to your first visit. This amount will be fully refunded following reimbursement from your insurance company.

POLICY STATEMENT: SPECIALTY REFERRAL POLICY _____ Initial

- Many private insurances allow patients to self-refer to specialists. We are happy to make recommendations for you.
- We work hard to maintain relationships with specialists. When you fail to show up to a referral appointment we have made for you, it reflects poorly on us and jeopardizes our ability to refer patients to these specialists in the future.
- Therefore, similar to our 24-Hour Cancellation/No Show Policy, if you repeatedly fail to show to a referred appointment, you will be dismissed from the practice.

POLICY STATEMENT: ATTENDING TO CHILDREN _____ Initial

- We know that it can be difficult to find childcare. However, the clinic is full of dangerous items.
- **Please monitor your children at all times while at the clinic.** We will not monitor your children during your office visit.
- We love kids, however children should not be present during procedures. It's unsafe.

Thank you and we look forward to caring for you and your family for years to come.
Hands On Medicine, Primary Care Family Practice

I have read and understand the Privacy Policy and above statement for Hands On Medicine.

Signature: _____ If Parent or Guardian, Name of Child: _____ Date: _____



(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex:
Mailing address:			City:		State and zip code:		
Social Security no:		Email address (optional):		Home phone:		Cell phone:	
Occupation:		Employer:			Employer phone no.: ()		
Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Internet
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Flyer	<input type="checkbox"/> Other			
INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.: ()	
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
PRIMARY INSURANCE:							
Subscriber's name (if different):		Subscriber's S.S. no.:	Birth date:	ID#:	Group#:		Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
SECONDARY INSURANCE (if applicable):		Subscriber's name and birth date:			ID#:		Group#:
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()	

APPOINTMENT CANCELLATION AND BILLING POLICY

We realize that emergencies occur, however in order to help us be available to patients who would like to be seen we request that you notify us within a minimum of 24-hours if you need to cancel or reschedule an appointment. A \$50 "NO SHOW" FEE MAY APPLY. As a courtesy to our patients, we will bill your insurance for you. Keep in mind that even though your insurance will be billed you are ultimately responsible for your bill.

The above information is true to the best of my knowledge. I authorize Hands On Medicine to treat me. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hands On Medicine to release any information required to process my claims.

Patient/Guardian signature

Date



Today's Date: _____

Your Child's Health History

Please take the time to fill in this information. It really helps streamline our time together.

Name: _____ **Age:** _____ **Date of Birth:** _____

How long has it been since your child's last medical evaluation?: _____

Please specify any specific issues or problems you would like to address today:

Is your child up-to-date with immunizations?: Yes/No (Please bring vaccination records)

Comments: _____

Personal Medical History: *Please tick the appropriate circle*

	Current	Past	No		Current	Past	No
Eye/Vision Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Gastrointestinal disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ear/Hearing Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Acid reflux:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Attention Deficit:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Frequent bladder infections:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney disease:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Incontinence:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anemia:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory problems/Asthma:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding/clotting disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hepatitis/HIV/AIDS:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Seasonal allergies:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Skin disorder:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sleep problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Type: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Serious infections:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Seizures/Epilepsy:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental Health Problems:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Developmental Delays:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other illnesses/surgeries/hospitalizations: _____

Current Medications (prescription & non-prescription, please include dose):

Herbs or Supplements (including fluoride and multi-vitamins):

What pharmacy do you use?: _____

Today's Date:

Patient Name:

Please list any **allergies or sensitivities to medications:** Check here if **none:**

Allergy:

Type of reaction:

If you have **personal reasons to not receive** blood products, please check here:

Family History:

	Relationship to child		Relationship to child
Diabetes	_____	Alcoholism/Addiction	_____
Heart disease	_____	Depression/Anxiety	_____
High blood pressure	_____	Bleeding disorder	_____
High Cholesterol	_____	Strokes	_____
Cancer	_____	Arthritis	_____
Other	_____	Thyroid disease	_____
Other	_____	Osteoporosis	_____

List all other medical providers your child receives care from (Dentist, Naturopath, etc.): _____

Does your child follow any special diet? If yes, please describe: _____

Is your child exposed to any smoke (tobacco, pipe, marijuana)?: _____

Was your child exposed to drugs or alcohol during pregnancy?: _____

Are there any weapons in the house?: _____

Is your child presently or has your child ever been exposed to any domestic violence?: _____

	Yes	No	
Does your child drink juice or soda?	<input type="radio"/>	<input type="radio"/>	How many per day?: _____
Does your child receive exercise?	<input type="radio"/>	<input type="radio"/>	Please describe: _____
Does your child watch TV/computer?	<input type="radio"/>	<input type="radio"/>	How many hours per day?: _____
Does your child brush their own teeth?	<input type="radio"/>	<input type="radio"/>	How many times per day?: _____
Who lives in your child's house?:	_____		

Where does your child sleep?: _____ How many hours per day?: _____

Child's School and grade?: _____ Academic Problems? Yes No

After School Activities: _____

Do child's biological parents or caretakers have a tendency for depression/anxiety? Yes No

Has the child's caregiver ever had drug or alcohol treatment?: _____

Do you and your child have social support (church, community groups, family)?: _____

Birth History

Carried to term?: _____ Vaginally Delivered?: _____ Hospital Delivery?: _____

Complications during pregnancy: _____

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Authorization for Another to Consent to Treatment of a Child

I _____, parent, guardian, or legal representative of
_____, (Date of birth) _____,

Give permission to the following people to consent medical care for above child in my absence:

	Name	Relation to Child	Age
1			
2			
3			

The medical care is defined as routine health care; including prescribed immunizations and medications, treatment for illness, injuries or medical emergencies.

The people named above **MAY NOT** give consent for my child to have the following treatments or procedures in my absence:

Please list any allergies or serious medical conditions this child has:

This authorization form will be effective for one (1) year from the date signed of my signature and may be cancelled at any time by written notice, or changed by a new copy of this form for my child's medical record.

Signature of Parent, Guardian or Legal Representative

Relationship/Date



REQUEST AND AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL INFORMATION

From:

Provider/Facility Name _____

_____ Phone Number

_____ Fax Number

To:

Provider/Facility Name _____

_____ Phone Number

_____ Fax Number

_____ Patient Name

_____ Date of Birth

_____ Social Security

_____ Patient Address

_____ City, State

_____ Patient's Phone Number

INFORMATION REQUESTED:

- Entire Medical Records
 Laboratory Test Results
 X-ray, CT, MRI, US and Reports
 Other/Specific Information Only: Please Specify _____

PURPOSE OF RELEASE: (Optional) TRANSFER OF CARE

- Convenience
 Dissatisfied with Practitioner
 Dissatisfied with Staff
 Moved Out of Service Area
 Change of Insurance

COORDINATION OF CARE

- Referral/Consultation
 Personal Use
 Legal
 Other _____

If you DO NOT consent to release of the following records, corresponding boxes must be INITIALED:

- HIV/AIDS Related Records
 Genetic Testing Information
 Mental Health Information
 Drug/Alcohol Diagnosis, Treatment or Referral Information

By signing below I agree to release the aforementioned health information and I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan. I understand that I may revoke this authorization in writing at any time, to the extent that action has been taken in reliance upon this authorization.

If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on (insert applicable date or event) There may be fees for providing copies.

(Signature of patient or person authorized by law)

(Date)

Check here if you are the parent or guardian.



Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can obtain access to the information.

PLEASE REVIEW CAREFULLY

OUR RESPONSIBILITY

By law we are required to safeguard your PROTECTED HEALTH INFORMATION (PHI). Your PHI includes data about past, present, future health condition, the services provided to you, and payment for said health care. This notice advises you of your rights and explains when, why, and how we can legally release, transfers, give, or otherwise reveal your PHI to a third party outside our practice. We take these responsibilities seriously and promise to make every effort to execute them in an efficient manner.

YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- **Review and receive copies**

You may review and/or receive copies of your PHI, such as medical records and billing data. Under certain circumstances, a summary or explanation of your PHI may be more helpful than the actual copies. If you agree, we will provide your health care information in the form you request. The first copy of your records is gratis, however additional copies will be billed as per Oregon Administrative Rule 847-012-000. In limited situations, we may deny some or all of your request. If we do, we will provide our rationale in writing and offer an appeal procedure.

- **Request limits to uses and disclosures**

You may request a restriction or limitation on your PHI used or disclosed for treatment, payment, or health care operations. You can also request limitation on information disclosed to someone who is involved in your care or the payment for it, such as a family member or a friend. We are not required to agree to your request. If we do agree we will comply with your request unless the information is needed to provide emergency treatment.

- **Correct or update**

You may request that we correct or add to your medical record if you believe there is a mistake or that important information is missing.

- **Request accounting of disclosures**

You have the right to ask for disclosures of your PHI.

- **Receive confidential communication by alternative means or at a secondary location.**

We will accommodate any reasonable request to use alternative means of communication or use a secondary address.

WE MAY USE AND DISCLOSE YOUR HEALTH CARE INFORMATION IN THE FOLLOWING WAYS

- **Treatment**

We may disclose your PHI to practitioners, office staff or other personnel in our clinic. We may also disclose your health care information to other providers who are involved in taking care of you and your health.

- **Health care operations**

We may use and disclose your PHI to facilitate efficient operation of our practice and insure that you receive quality care.

- **Payment**

We may disclose your PHI to bill and collect payment for the treatment and services we provide.

- **Appointment reminders**

We may contact you as a reminder that you have an appointment.

- **Treatment Alternatives**

We may contact you to inform you about possible treatment options that we feel may be of interest to you.

- **Health related products and services**

We may tell you about health related products or services that may interest you.

WE MAY ALSO USE YOUR PHI IN SPECIAL SITUATIONS

- **To avert a serious threat to health or safety**

We may use or disclose your PHI to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **As required by law**

We may use or disclose your PHI when required to do so by federal, state or local law.

- **Research**

We may use and disclose your PHI for research projects that are subject to a special approval process. All research projects are subject to a special approval process that governs patient safety, welfare and the privacy of your medical information. We will ask for your permission if the researcher will have access to your name, address or other information that reveals your identity.

- **Organ and tissue donation**

If you are an organ donor, we may release PHI to organizations that handle organ procurement as necessary to facilitate such donation and transplantation.

- **Military, veterans, national security and intelligence**

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

- **Worker's compensation**

We may release your PHI to worker's compensation or programs that provide benefits for work related injuries or illness.

- **Public health risk**

We may disclose your PHI to prevent or control disease, injury or disability. We are also required to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with specific products.

- **Health oversight**

We may disclose your PHI to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and comply with civil rights laws.

- **Lawsuits and disputes**

We may disclose your PHI in response to law enforcement or a court order, subpoena, warrant, summons, or similar process.

- **Coroners, medical examiners and funeral directors**

We may release your PHI to determine the cause of death or for other official duties.

- **Information not personally identifiable**

We may disclose your PHI in a way that does not personally identify you or reveal your identity.

- **Family and friends**

We may disclose your PHI to your family members or friends if we obtain verbal agreement or if we give you an opportunity to object and you are not capable of giving consent because you are not present or you are incapacitated, we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only information relevant to your care.

- **Specific types of PHI**

There are more restrictive regulations for use and disclosure of some types of PHI for example, drug and alcohol treatment, HIV, mental health, or genetics testing information. Even so, there are circumstances in which these types of information may be used or disclosed with out your authorization.

- **All other uses and disclosures of your PHI require your prior written consent**

Except for those uses and disclosures described above, we will not release health care information about you without your written consent.

CHANGES TO THIS NOTICE

We are allowed to change out privacy practices as long as they are consistent with state and federal laws. If we do revise them, we will promptly notify our active patients.

If you have any questions about this notice or if you are concerned that your privacy has been violated please contact us at (503)281-0308