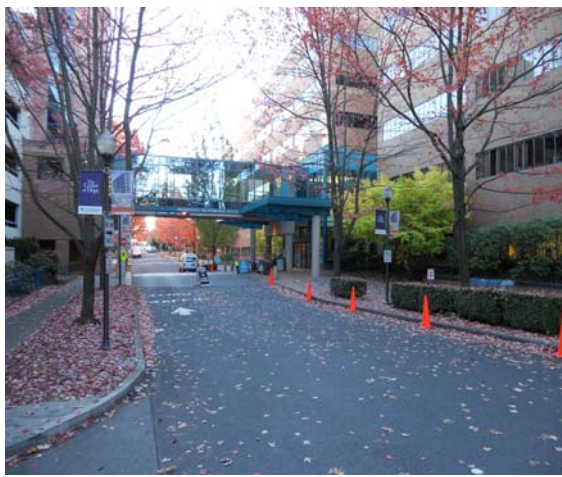




Oregon Pediatrics - NE Portland, PC  
5050 NE Hoyt St., Suite B55  
Portland, Oregon 97213-2944  
(503) 233-5393





- Clackamas Pediatric Clinic, 9290 SE Sunnybrook Blvd., #200, Clackamas, Oregon 97015 (503) 659-1694
- Oregon Pediatrics - NE Portland, PC, 5050 NE Hoyt St., #B55, Portland, OR 97213 (503) 233-5393
- Oregon Pediatrics - Happy Valley, PC, 16144 SE Happy Valley Town Ctr. Dr., Happy Valley, OR 97086 (503) 427-2637
- Oregon Pediatrics - Meridian Park, LLC, 19260 SW 65th Ave., #275, Tualatin, OR 97062 (503) 691-2519

So we may properly contact you regarding medical care and correctly bill your insurance, please supply all information below.

PATIENT	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:					PO Box (if applicable):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
	City:			State:	Zip + 4:		Social Security #:		
	Primary Contact Phone:			<input type="checkbox"/> Home <input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell	<input type="checkbox"/> Other: <input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work	Other Phone:		<input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell <input type="checkbox"/> Other:	<input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work
	Secondary Phone:			<input type="checkbox"/> Home <input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell	<input type="checkbox"/> Other: <input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work	Other Phone:		<input type="checkbox"/> Mom Cell <input type="checkbox"/> Dad Cell <input type="checkbox"/> Other:	<input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Work
	Email:				Preferred Physician:		School or Employer Name:		

PARENT/GUARDIAN	Circle/complete as applicable:    Parent    Step-Parent    Foster Parent    Grandparent    Aunt    Uncle    Other:								
	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:					PO Box (if applicable):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
	City:			State:	Zip + 4:		Social Security #:		
	Primary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Marital Status:		Drivers License/State ID #:		
	Secondary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Email:				
	Employer:			Occupation:			Work Phone (if not otherwise listed):		

PARENT/GUARDIAN	Circle/complete as applicable:    Parent    Step-Parent    Foster Parent    Grandparent    Aunt    Uncle    Other:								
	Last Name:		First Name:		MI:	Suffix:	Preferred/Nick Name:		
	Physical Address:					PO Box (if applicable):		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:
	City:			State:	Zip + 4:		Social Security #:		
	Primary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Marital Status:		Drivers License/State ID #:		
	Secondary Phone (if different than above):		<input type="checkbox"/> Home <input type="checkbox"/> Cell	<input type="checkbox"/> Work <input type="checkbox"/> Other:	Email:				
	Employer:			Occupation:			Work Phone (if not otherwise listed):		

PRIMARY	Insurance Name:		Identification #:			Group #:	
	Address:		City	State:	Zip:	Effective Date:	
	Subscriber Name (Mother, Father...):		Subscriber DOB:	Subscriber SS#:		Coplay Amount:	

SECONDARY	Insurance Name:		Identification #:			Group #:	
	Address:		City	State:	Zip:	Effective Date:	
	Subscriber Name (Mother, Father...):		Subscriber DOB:	Subscriber SS#:		Coplay Amount:	

Contact	Emergency Contact:			Address:		
	Primary Phone:	Type:	Secondary Phone:	Type:	Relationship to child:	

Siblings	List names of siblings in same household:				
	DOB of each sibling:				

**Thank you for choosing Clackamas Pediatric Clinic and Oregon Pediatrics as your health care provider. Our goal is to provide the highest quality medical services to our patients at a reasonable cost.**  
Please note the following payment terms and feel free to speak to a bookkeeping representative if you have any questions or concerns.

- \* If you have insurance please be prepared to present your insurance card at each visit. We are happy to submit a bill to all major carriers as well as most secondary carriers when all necessary information to do so has been provided to us.
- \* Please note that your insurance coverage and benefit package is an arrangement between you and your insurance carrier. You are responsible to be aware of your benefits and to contact your carrier directly when issues arise. This includes timely payment of claims, denials, rebilling, contracted providers and other such issues. Many insurance plans have limitations on benefits, especially for preventative care (well child care &/or vaccinations). Please contact your insurance company directly to discuss your specific benefits and/or limitations. We are happy to assist whenever possible regarding general insurance benefit questions. We can not quote nor do we guarantee insurance benefits. Regardless of insurance, all services provided are the financial responsibility of the patient or the parent(s)/guardian(s) of patients who are minors.
- \* Patients opting to follow an alternate immunization schedule are subject to minimal office visit charge for "shot only" visits; and therefore may be subject to a copay at time of service, depending on your specific insurance plan benefits.
- \* Uninsured patients are expected to pay for services in full at the time of service unless other prior arrangements have been made.
- \* As a courtesy we will bill third party payors (such as auto insurances relating to motor vehicle accidents) when provided with complete insurance information at time of service. Balances for third party claims are subject to the same payment terms as other services received at CPC/OP.
- \* We offer a "Prompt Pay" discount on most professional services when all charges are paid in full at the time of service.
- \* Payment for services rendered are due within 30 days of receiving service. We accept cash, credit card & bank debit card. In many cases we can also accept personal checks and money orders. If you are unable to pay in full within 30 days please contact our office to see if you qualify for a payment plan. If approved, regular monthly payments must be made until paid in full.
- \* Accounts may be assigned to an outside collection agency and reported to the credit bureaus when the personal balance is over 120 days old and/or payment plan payments are missed. Patients whose account has been assigned to outside collections are responsible for all agency and/or legal fees incurred. Thereafter future services at CPC/OP are on a cash basis with no extension of credit and may also be subject to dismissal.
- \* Parents and/or patients 16 years of age and older; please provide photo ID.

**Additional Charges:**

- 1.5% monthly finance charge (18% APR) added to accounts with personal balance over 90 days old, *including* those for which a payment arrangement has been established. This policy is in effect for services 11-4-2008 & after.
- \$15 - Copay billing. Added to account if copay not paid at time of service. Non-urgent care may be subject to rescheduling when copay is not paid.
- \$25 - Returned check. Added to accounts for which check payment is not honored by the bank.
- \$50 - No Show. Added to account when the patient does not keep a scheduled appointment and doesn't cancel prior to appointment time.
- \$50 - Collection. Added to accounts assigned to an outside collection agency.

Your signature below constitutes your authorization for treatment; acceptance of the payment terms; authorization for Clackamas Pediatrics and/or Oregon Pediatrics to bill the insurance using information on file at the time of service; authorization to release medical data relating to a claim; and authorization to assign benefits directly to Clackamas Pediatric Clinic and/or Oregon Pediatrics.

\_\_\_\_\_  
Signature Relationship to patient Date



**Practice Limited to Infants, Children, & Adolescents**

- 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015 (503) 659-1694
- 5050 NE Hoyt St., #B55, Portland, Oregon 97213 (503) 233-5393
- 16144 SE Happy Valley Town Ctr. Dr., Happy Valley, OR 97086 (503) 427-2637
- 19260 SW 65<sup>th</sup> Ave., #275, Tualatin, OR 97062 (503) 691-2519

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please describe the primary concerns regarding your child's health:

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Duration of pregnancy: \_\_\_\_\_ Where was your child born: \_\_\_\_\_

Were there any newborn complications such as jaundice, breathing problems, or feeding difficulties?

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Please describe any significant past or ongoing medical problems:

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---

Are there any allergies to medication, pollens, dust, foods pets or insect stings?

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---

Are immunizations current?  Yes  No Did you bring a copy of the immunization record?  Yes  No

Please list any prescription medications your child is taking:

---

---

Family Medical History

Does any immediate family member (parents or siblings) have any of the following conditions?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anemia _____   | <input type="checkbox"/> Asthma _____    | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Diabetes _____  | <input type="checkbox"/> Thyroid Disease _____     |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Kidney Disease _____      |
| <input type="checkbox"/> Ulcers _____   | <input type="checkbox"/> Stroke _____    | <input type="checkbox"/> Heart Disease _____       |

Other \_\_\_\_\_

Environmental Safety

- |   |   |
|---|---|
| Any firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No      | Always uses car seat or seatbelt? <input type="checkbox"/> Yes <input type="checkbox"/> No                                  |
| Any tobacco use in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No   | Always use bicycle helmet? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a            |
| Exposure to domestic violence? <input type="checkbox"/> Yes <input type="checkbox"/> No | Appropriate after-school supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a |

Are there any other issues you would like the provider to be aware of?

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# ACKNOWLEDGMENT AND CONSENT

I understand that Clackamas Pediatric Clinic and/or Oregon Pediatrics (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

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 a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practice**

Patient Name (please print): \_\_\_\_\_

By: _____ (Patient Sign if 15 years old or older)	Date: _____
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-OR-

By: _____ (Patient representative sign if patient is under 15)	Date: _____
Description of Representative's Authority (Mother, Father, Guardian...): _____	

## NOTICE OF PRIVACY PRACTICES

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

**PLEASE REVIEW IT CAREFULLY.**

*If you have any questions about this notice, please contact our privacy officer, Carmen Minard in our office by calling (503) 659-1694 or visit us at our administrative offices located at Clackamas & Oregon Pediatrics, 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015-6777.*

### WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

### YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and service you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

**We are required by law to give you this notice.** It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Various personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

- **For payment.** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

- **Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.
- **Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

#### SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, 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. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information 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 compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), 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 health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

#### OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. 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 disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information.

#### YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the attention of Carmen Minard at our office address listed on the first page, in order to inspect and/or copy records 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.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **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.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to Carmen Minard at (503) 659-1694 at our Clackamas office.

We may deny your request for an amendment if your request 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, unless the person or entity that created the information is no longer available to make the amendment

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

**Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the 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.

To obtain this list, you must submit your request **in writing** to: Attn: Carmen Minard, Clackamas & Oregon Pediatrics, 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015-6777. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

**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 you emergency treatment or we are required by law to use or disclose the information.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to: Attn: Carmen Minard, Clackamas & Oregon Pediatrics, 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015-6777

- **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.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to Carmen Minard, Clackamas & Oregon Pediatrics, 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015-6777. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact Carmen Minard at (503) 659-1694 at our Clackamas office.

#### CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

#### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, call or write to Carmen Minard, Clackamas & Oregon Pediatrics, 9290 SE Sunnybrook Blvd., #200, Clackamas, OR 97015-6777. ***You will not be penalized for filing a complaint.***