Northwest PRIMARY CARE

# Adult Medical History Form

Legal Name: _____ DOB: _____ Date: _____

Preferred Name (if different than above): _____

**Marital Status: S M W D Partner**

**Occupation:** _____

**If retired, previous occupation:** _____

Household (who lives in your household?)

**List allergies/intolerances to medications (and the reaction they cause):**

**Personal Medical History: Circle Yes or No, explain yes answers (when occurred or was diagnosed)**

| | | |
|---|---|---|
| Alcoholism | Y | N |
| Anxiety Disorder | Y | N |
| Anemia | Y | N |
| Arthritis | Y | N |
| Asthma | Y | N |
| Bleeding tendency | Y | N |
| Blood clot | Y | N |
| Cholesterol (high) | Y | N |
| Cancer | Y | N |
| Depression | Y | N |
| Diabetes | Y | N |
| Emphysema/COPD | Y | N |
| Epilepsy | Y | N |
| Exposure to asbestos | Y | N |
| Exposure to TB | Y | N |
| Glaucoma | Y | N |
| Hayfever | Y | N |
| Heart disease | Y | N |
| Hepatitis (yellow jaundice) | Y | N |
| High blood pressure | Y | N |
| Kidney disease | Y | N |
| Kidney stone | Y | N |
| Migraines | Y | N |
| Osteoporosis | Y | N |
| Pneumonia | Y | N |
| Polio | Y | N |
| Recurrent bladder infection | Y | N |
| Rheumatic fever | Y | N |
| Sleep Apnea | Y | N |
| Stroke | Y | N |
| Thyroid disease | Y | N |
| Tuberculosis | Y | N |
| Ulcer | Y | N |
| Other serious illness | Y | N |

**Please list all operations, including year performed:**

**Family History (Blood Relatives)**

| | Age at Death | If living, list any health problems (heart disease, cancer, diabetes, high blood pressure, etc.). If deceased, cause of death. |
|---|---|---|
| Father | | |
| Mother | | |
| Maternal Grandparents | | |
| 1 | | |
| 2 | | |
| Paternal Grandparents | | |
| 1 | | |
| 2 | | |
| Brothers and Sisters | | |
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |
| Children | | |
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| (Females) Number of pregnancies: | | |
| Number of births: | | |

**Health Maintenance** (answer applicable questions)

When was last pap smear?

When was last mammogram?

Have you had a bone density test? Y N If yes, when?

Have you had a colonoscopy? Y N If yes, when?

Do you have a Living Will/Advanced Directives? Y N

**Immunizations**

When was last tetanus vaccine?

Have you had a pneumonia vaccine? Y N If yes, when?

| **Safety/Social Habits (please circle answers)** | | | |
|---|---|---|---|
| Do you use alcohol? | Y | N | Past |
| If so, how much per day? | | | |
| Do you use tobacco? | Y | N | Past |
| If yes, how much per day? | | | |
| If in past, when did you quit? | | | |
| Are you exposed to secondhand smoke in your home? | Y | N | Past |
| Do you use caffeine, coffee, tea, soda? (circle one) | | | |
| If so, how much per day? | | | |
| Do you use "recreational drugs"? | Y | N | Past |
| If yes, what do you use? | | | |
| Are you sexually active? | Y | N | |
| If so, with whom? | males | females | both |
| What do you do for exercise? | | | |
| How often do you exercise? | | | |
| Have you ever been abused? | physically | mentally | sexually |
| Are you satisfied with your weight? | Y | N | |
| Do you always wear a seatbelt? | Y | N | |
| If you ride a bike or motorcycle, do you always wear a helmet? | Y | N | |
| Are guns kept in your home? | Y | N | |
| If yes, is household aware of gun safety? | Y | N | |

FORM CONTINUES ON THE OTHER SIDE

# Review of Systems

Do you **now have**, or have you **recently had** problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in the space provided.

| **Constitutional Symptoms** | | |
|---|---|---|
| Fever | Y | N |
| Chills | Y | N |
| Headache | Y | N |
| Weight loss/gain | Y | N |
| Other: | Y | N |
| **Ear/Nose/Throat/Mouth** | | |
| Ear symptoms | Y | N |
| Sore throat | Y | N |
| Sinus problems | Y | N |
| Other: | Y | N |
| **Hematologic/Lymphatic** | | |
| Swollen glands | Y | N |
| Easy bruising | Y | N |
| Other: | Y | N |
| **Cardiac** | | |
| Chest Pains | Y | N |
| Irregular heartbeats | Y | N |
| Other: | Y | N |
| **Respiratory** | | |
| Wheezing | Y | N |
| Frequent cough | Y | N |
| Shortness of breath | Y | N |
| Other: | Y | N |
| **Gastrointestinal** | | |
| Abdominal pain | Y | N |
| Nausea/vomiting | Y | N |
| Black or bloody stools | Y | N |
| Diarrhea | Y | N |
| Other: | Y | N |

| **Genitourinary** | | |
|---|---|---|
| Painful urination | Y | N |
| Urinary incontinence | Y | N |
| Blood in urine | Y | N |
| Other: | Y | N |
| **Dermatologic** | | |
| Skin rash | Y | N |
| Mole change | Y | N |
| Other: | Y | N |
| **Gynecologic** | | |
| Pelvic pain | Y | N |
| Irregular periods | Y | N |
| Painful periods | Y | N |
| Vaginal discharge | Y | N |
| Other: | Y | N |
| **Musculoskeletal** | | |
| Joint pain | Y | N |
| Neck pain | Y | N |
| Back pain | Y | N |
| Other: | Y | N |
| **Endocrine** | | |
| Excessive thirst | Y | N |
| Too hot/cold | Y | N |
| Tired/sluggish | Y | N |
| Other: | Y | N |
| **Psychologic** | | |
| Do you have depressed feelings? | Y | N |
| Have you considered suicide? | Y | N |
| Sleep disturbance? | Y | N |
| Other: | Y | N |

What do you do for fun?

Physician Use Only: (comments/notes)

| # Answer | Level of Service |
|---|---|
| 0 - 1 | 1 or 2 |
| 2 - 9 | 3 |
| 10+ | 4 or 5 |

Physician: _____ Date: _____

# Authorization to Release Medical Information

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B _____
*Street, City, State, Zip*

Home Phone _____ Work Phone _____ S.S.# _____

| **I Authorize Information Released FROM:** (Please Print) | **Please Send My Records TO:** (Please Print) |
|---|---|
| Name _____ | Name _____ |
| Address _____ | Address _____ |
| City, State, Zip _____ | City, State, Zip _____ |

**Purpose of Release**

- ☐ Dissatisfied with practitioner
- ☐ Dissatisfied with staff
- ☐ Transfer of care
- ☐ Moving
- ☐ Personal use
- ☐ Insurance change
- ☐ Referral/Consultation
- ☐ Legal
- ☐ Other _____

**Permission to Fax Information:** I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

**I would like records sent via:** ☐ CD (Adobe 8 or higher) ☐ Paper (***If not checked, CD is the default method.)***

## Type of Information To Be Released

☐ General Medical Records (Consists of the last two years of treatment)

☐ **Specific Information Only**: please specify _____

**Protected or Sensitive Information:** I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALING** I authorize the release of the following protected or sensitive information:

_____ Initial Drug/Alcohol Diagnosis/Treatment/Referral Information

_____ Initial Genetic Testing Information

_____ Initial Mental Health/Treatment

_____ Initial HIV/AIDS Information

You will not be denied treatment if you refuse to sign the authorization form unless treatment to be provided is considered research related treatment.

You have the right to revoke this authorization at any time, provided that you do so in writing to Northwest Primary Care Group. 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.

This authorization will expire in 180 days from the date of signing, or unless otherwise specified _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

BY: _____ DATE: _____
Patient or Patient Representative

Description of Representative's Authority: _____

☐ **Dwyer Clinic**
Internal Medicine
10024 SE 32nd Ave • Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.654.5666

☐ **Milwaukie Clinic**
Family Medicine
3033 SE Monroe St • Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.659.4730

☐ **Talbert Clinic**
Family Medicine
12360 SE Sunnyside Rd • Clackamas, OR 97015
PH: 503.659.4988 • FX: 503.698.4018

☐ **Oregon City Clinic**
Family Medicine
1508 Division St • Building II, Suite 25
Oregon City, OR 97045
PH: 503.659.4988 • FX: 503.353.1234

☐ **Sellwood Clinic**
Family Medicine
6327 SE Milwaukie Ave • Portland, OR 97202
PH: 503.659.4988 • FX: 503.353.1297

☐ **Medical Records**
12300 SE Mallard Way, Ste 160
Milwaukie, OR 97222
PH: 503.659.4988 • FX: 503.353.1293

## Instructions for completing NWPC Record Release Form:

*(Important: any missing or inaccurate entries may delay or void your request)*

- Photo ID may be required for patient/guardian verification
- Be sure to write legibly, to include:
    - Birthdate
    - Previous name (if any)
    - Where would you like the records sent (include address or fax number)
    - Why the records are being sent (purpose of release)
    - Type of information to be released (standard for “all records” is last two years of treatment unless specifically requested otherwise).
    - Patient/guardian signature and date
- If you want the information to be faxed, please mark on the form, “Permission to Fax”. Please note that we will not fax any records that are more than 50 pages.
- Please allow 30 days for records to be sent as per Oregon State Law.

## Who can receive copies of medical records:

**Adult patients** - Copies of their own medical records

**Parent or Legal Guardian** - Copies of their minor child’s medical records

**Legal Power of Attorney** - Copies of the medical records of the person named in the power of attorney (for example; wife, husband or partner, disabled adult)

Northwest PRIMARY CARE

# Personal Health Information (PHI) Consent Form

**Your privacy is our most important goal. Federal law requires that your information may not be shared with anyone, unless law allows it or permission has been given.**

**Please note: Anyone listed below as having permission to have access to your Protected Health Information, (whether on paper, electronic, or verbal) will have access that may include specially protected records (i.e. HIV results) ORS 333-022-0210.**

I _____ , **DOB**_____ authorize the following person(s)to discuss, receive written documents and/or have access to My NWPC Chart with all my personal health information (PHI), which consists of Billing/Insurance, Appointments, and all Health Information and Treatments. Leave blank if you do not want your information to be shared:

1._____ Relationship:_____

2._____ Relationship:_____

3._____ Relationship:_____

4._____ Relationship:_____

**NWPC normally will not leave detailed voice mail messages due to HIPAA concerns, unless:**

◯ I also authorize NWPC to leave a detailed message on the phone number(s) listed here:

_____

Patient Signature:_____ Date: _____

***'My NWPC Chart'*** Email Address:

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |

**** If at any time you wish to rescind your consent, you must update this consent form at one of our clinics.****

## Missed and Canceled Appointments

We request that you notify us 24 hours in advance when canceling a scheduled appointment. We reserve the right to charge a fee of $40 for any appointment missed or canceled without reasonable notice.

## Financial Responsibility

Patients or their legal guardian are financially responsible for all services received. If you do not pay your co-payment at the time of service, a $25 billing fee will be charged. Overdue accounts are subject to a rebilling fee of $10 per month and may be placed on a cash payment basis for future appointments. If you are required to pay for treatment at the time of service and are unable, your appointment may be rescheduled. A $25 fee will be assessed for checks returned by your bank for any reason. Failure to meet your financial responsibility may result in collection or legal actions. Accounts that are turned over to a collection agency will be assessed a collection account fee of 10% of the outstanding balance.

## Credit and Payment Policy

Due to the changing nature of health insurance, this policy is subject to change without advance notice. For an updated copy, ask at our Registration Desk or check our Web site at nwpc.com.

**YOU MAY CONTACT OUR CREDIT DEPARTMENT AT 503.659.4777**

# Credit and Payment Policy

To make a clinic appointment

**503.659.4988**

**NWPC.com**

DWYER CLINIC
10024 SE 32nd Avenue
Milwaukie, OR 97222
503.659.4988

Hours:
Mon-Fri 8AM-5PM

MILWAUKIE CLINIC
3033 SE Monroe Street
Milwaukie, OR 97222
503.659.4988

Hours:
Mon 8AM-5PM
Tues, Wed, Thurs 8AM-8PM
Fri 8AM-5PM
Sat 8AM-3PM

OREGON CITY CLINIC
Providence Willamette Falls Medical Center
1508 Division Street, Medical Plaza II
Lower Level, Suite 25,
Oregon City, OR 97045
503.659.4988

Hours:
Mon-Fri 8AM-5PM

SELLWOOD CLINIC
6327 SE Milwaukie Avenue
Portland, OR 97202
503.659.4988

Hours:
Mon-Fri 8AM-5PM

TALBERT CLINIC
12360 SE Sunnyside Road
Clackamas, OR 97015
503.659.4988

Hours:
Mon-Fri 8AM-5PM


Northwest PRIMARY CARE

Northwest PRIMARY CARE

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# Credit and Payment Policy

We are pleased that you have chosen Northwest Primary Care Group, PC, as Your Family's Medical Home. We provide you with the highest level of professional medical care possible, while keeping medical costs reasonable. In an effort to provide quality medical services, we have established the following credit and payment policies:

## Insurance Coverage

We will submit claims on your behalf to your primary and secondary insurance carriers. When insurance information is unavailable or invalid insurance is provided at the time of service, the patient or their legal guardian is responsible for all charges incurred.

Your insurance contract is between you and your carrier. Any remaining patient balance after your insurance carrier(s) has made payment is due immediately upon receipt of your Northwest Primary Care account statement. Patients or their legal guardian are required to bring a photo ID, their current insurance identification card(s) and the applicable co-payment to each appointment.

If you have questions or concerns about your insurance coverage, please call your carrier. It is the responsibility of each patient or their legal guardian to understand the terms and conditions of their insurance plan(s).

## No Insurance Coverage

We offer SureCare, a program designed for patients who do not have insurance coverage. The fees for office visits and services are discounted. SureCare provides the same quality care from our primary care practitioners you've come to expect, with the benefit of discounted pricing.

When calling for an appointment, let our scheduler know that you would like to use the SureCare program. The scheduler will inform you of the exact fee for your office visit. This fee is collected upon registration at the office visit. You will be given a discounted fee schedule of our lab, radiology and other ancillary services which may be recommended by your physician. When meeting with your physician, it will be your decision whether or not you want those services. For more information about our SureCare program, please check our website nwpc.com or ask a staff member.

We accept cash, personal check, money order, VISA and MasterCard payments.

## Workers Compensation

Please notify our Registration Desk at each appointment if your visit is due to an injury covered by workers compensation. You will need the name of your workers compensation insurance carrier, the date of your injury, the name and address of your employer at the time of injury, and the claim number when filing a workers compensation claim. If you have questions or concerns about your insurance coverage, please call your carrier. It is your responsibility to negotiate a disputed claim. If you are without health insurance coverage or are covered by an insurance plan that we don't accept, we cannot see you for workers compensation.

## Motor Vehicle or Other Liability Claims

We provide complimentary billing of your motor vehicle or other liability insurance carrier, when you provide accurate and complete billing information at the time of your initial visit. We verify your claim information and the availability of personal injury protection coverage (PIP) on your claim. If your PIP has been exhausted or expired, we will bill your private medical insurance coverage. If you do not have medical health insurance, Northwest Primary Care, requires a deposit on your account of $150 at each visit.

In the event that your claim is disputed or a suit is established against another party, Northwest Primary Care, will not accept the responsibility for collecting or negotiating settlements. Patients will be asked to work with our business office to establish a suitable payment plan for your medical charges. While we understand that settlement of these cases can take months, claims against another party are not a reason for non–payment of the medical services you have received.