

**NORTHEAST OREGON
SURGICAL CLINIC**

Dr. Andrew Bower

PATIENT REGISTRATION

PATIENT INFORMATION

Social Security # _____ Date of Birth ____/____/____ Sex M F
 First Name _____ Middle _____ Last Name _____
 Mailing Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
 Email _____ Marital Status Married Single Divorced Widowed
 Employment Status Employed Retired Self-Employed Full-time Student Unemployed
 Employer/Company Name _____
 Referring Physician _____ How did you hear of us? _____

INSURANCE INFORMATION (please provide your insurance card to the receptionist)

Insurance Company _____ Policy # _____ Group # _____
 Insured/Card Holder's Name _____ Relationship _____
 Social Security # _____ Date of Birth ____/____/____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company _____ Policy # _____ Group # _____
 Insured/Card Holder's Name _____ Relationship _____
 Social Security # _____ Date of Birth ____/____/____

PHARMACY INFORMATION

If Dr. Bower writes a prescription for you, what pharmacy would you like it sent to?

- Pendleton Bi-Mart Pendleton Safeway Yellowhawk Pharmacy
 Pendleton Rite-Aid Pendleton Wal-Mart Other: _____

EMERGENCY CONTACT

First Name _____ Last Name _____ Relationship _____ Sex M F
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

SPOUSE GUARANTOR RESPONSIBLE PARTY (please check one)

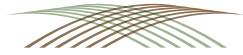
First Name _____ Middle _____ Last Name _____ Sex M F
 Relationship _____ Social Security # _____ Date of Birth ____/____/____
 Mailing Address _____ City _____ State _____ Zip _____
 Email _____ Employer _____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her service as described realizing I am responsible to pay non-covered services.

Patient Signature (or Parent if Minor)

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

Date



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NOTICE OF PRIVACY PRACTICES (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others except those involved in your continued care unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get any information about it by contacting our office manager. A fee may apply.

Please list any individuals (family members, etc.) to whom you give us permission to discuss and/or release your medical records to:

Authorized individual

Authorized individual

In order to ensure your privacy, you will be asked to provide your photo ID which will be copied and retained within your chart for identification purposes.

Before our office will release your information we will take reasonable precautions to ensure they are indeed one of the people or part of an entity which you have listed above and/or are involved with your direct medical care. Your information is automatically released to offices, hospitals, labs, etc. for the purpose of treatment, payment or health care operations, per the HIPAA Privacy Act.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information is available for you in our waiting room.

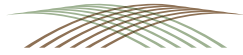
By my signature below I acknowledge I was given the opportunity to receive the Notice of Privacy Practices and I wish for my information to be released to those individuals or entities indicated above.

Patient signature (or legally-authorized individual)

Date

Printed name (if signed on behalf of the patient)

Relationship



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FINANCIAL POLICIES

As a service to our patients, we would like to outline our policy toward the payment for services.

1. Patient co-payments are expected at the time of the appointment. If a patient is not aware of his or her co-pay amount, the average co-pay of \$25 will be collected at the time of service. If adjustments are to be made, the company will do so promptly after the Explanation of Benefits is received from the third party payer.
2. Although we are billing your insurance companies as a courtesy to you, we hold you responsible for your account. If the insurance information you provide us is incorrect, you will be responsible to pay your account in full within 30 days, you may then bill your insurance company yourself to obtain reimbursement.
3. All accounts are to be paid off in full within 30 days unless prior payment arrangements have been established in writing.
4. If the problem for which you are seeing the physician involves litigation, such as may result from an automobile or work-related accident, be advised that we do not wait for payment until litigation is settled.
5. Your signature authorizes us to contact references in the event it becomes necessary to locate you.
6. Past due accounts are required to pay cash in full at the time of service.
7. All credit balances may be held as credits against future services rendered unless credit refunds are requested in writing by the patient and patient care has been deemed complete by the physician.
8. A one-time processing charge of \$25 and a 1 % per month (9% per year) will be imposed on all accounts 60 days past due.
9. A \$25 fee will be charged on all checks returned to the bank for lack of funds and are subject to Oregon Law, ORS 30.700, which states legal action can be taken for three (3) times the amount of the check or \$100, whichever is greater.
10. In the event you do not give at least a 24-hour notice prior to canceling an appointment and/or if you do not show for a scheduled appointment or procedure, there will be a \$25 administrative scheduling fee assessed.
11. Dr. Andrew Bower's charges and fees are irrespective of St. Anthony Hospital's or other provider's charges and fees.
12. Financial Aid agreed to by St. Anthony Hospital or other providers does not apply to our office, or to Dr. Andrew Bower's charges.
13. Patient portion of charges are determined by your individual insurance policy. The patient responsibility portion of charges must be collected by our office per a legally binding contract that Dr. Andrew Bower holds with them. This contract allows us to be a "Preferred Provider" and/or "Participating Provider".
14. Your deductible, co-payment and/or co-insurance are all determined by your insurance company. If you have any questions or concerns regarding these items, please contact your insurance company.
15. You are encouraged to contact the Clinic Administrator if you have any questions regarding your account or if you do not fully understand these policies.

By my signature below, I acknowledge that I was given the opportunity to read these financial policies and to ask questions. I now fully understand the financial policies.

PATIENT SIGNATURE (OR LEGALLY-AUTHORIZED INDIVIDUAL)

DATE

PRINTED NAME (IF SIGNED ON BEHALF OF THE PATIENT)

RELATIONSHIP

HEALTH QUESTIONNAIRE

Date ___ / ___ / ___

Patient's Name _____ Date of Birth ___ / ___ / ___

Referring Doctor _____ Primary Care Doctor _____

Reason for today's visit _____

List any serious **childhood** illnesses (polio, rheumatic fever, etc.) _____

List all **allergies** to medications, iodine or latex _____

List all **medications** (include over the counter medication and dose) you are currently taking _____

Check box if you need to attach a list of medications to this form

List all **past serious medical problems** _____

List all previous **surgery** (and date) _____

Do you use **tobacco**?

Don't use tobacco

Cigarettes: ___ packs/day

Cigars: ___ cigars/day

Chew/Snuff: ___ cans/day

How much **alcohol** do
you drink a day?

Never Smoked

Don't drink alcohol

___ shots/day

Do you drink
caffeine?

___ cans/day

___ ounces/day

Yes No

How much/day _____

Have any of your relatives (grandparents, parents, brothers, or sisters) had:

Cancer (and list type) _____

Heart disease _____

Abnormal reaction to anesthesia _____

Does your religion prohibit blood transfusions? Yes No

Do you use street, herbal or non-prescription drugs? Yes No

Have you had any exposure to Hepatitis, TB or HIV? Yes No

Females: Are you pregnant? Yes No

Name _____

HEALTH QUESTIONNAIRE (page 2)

Do you have loose, chipped, false teeth, bridgework or crowns caps? Yes No

Family History:

Have any of your relatives (maternal/paternal grandparents, parents, brothers, or sisters had:

Cancer (list type) _____

Colon Cancer _____

Heart Disease _____

Abnormal reaction to anesthesia _____

Colonic polyps _____

Have you ever had:

An abnormal reaction to anesthesia _____

A colonoscopy (when, by whom and results) _____

An upper endoscopy (EGD) _____

An EKG (when and where) _____

When did you last have your blood drawn and where _____

Chief Complaint/History of Present Illness:

What are the symptoms that brought you to the office today? _____

When did these symptoms first begin? _____

Is this an on-the-job injury? Yes No

If you are experiencing pain, please describe the location of the pain: _____

What makes the pain go away or get better? _____

What makes the pain worse? _____

On the pain chart of zero to 10, zero is no pain at all and 10 is unbearable pain, please mark the level of your pain: right now _____ when you walk _____ when you sit _____

when lifting something _____ when you bend _____ when you lay flat _____

Is your pain: sharp dull constant intermittent burning

Have you had any images (x-rays, CT scan an MRI etc....) Yes No

Where: _____

Why: _____

Name _____

HEALTH QUESTIONNAIRE (page 3)

Review of Systems: Circle if you have any of these issues:

General: weight loss, weight gain, fever, chills, fatigue, night sweats

Eyes: glaucoma, glasses, contacts, cataracts

ENT: earache, hearing loss, ringing in ears, hearing aids, nose bleeds, hoarseness,
throat pain, neck stiffness, lump or swelling in neck

Cardiac: chest pain or discomfort, artificial heart valve/stint, fast heart rate, palpitations, high
blood pressure, pacemaker

Respiratory: shortness of breath, cough, coughing up blood, sleep apnea, asthma, CPAP machine

Gastrointestinal: difficulty swallowing, constipation, heartburn, nausea, abdominal pain, diarrhea,
black or bloody stools, poor appetite, ulcers, gallstones

Genitourinary: painful or difficult urination, increased urinary frequency, blood in urine,
kidney stones

Musculoskeletal: artificial joint or joint pain (specify joint) _____ metal in body

Neurological: numbness, weakness, seizures, loss of memory, poor balance

Psychological: sleep disturbances, anxiety, depression, claustrophobia, panic attack

Endocrine: excessive thirst, excessive sweating, diabetic

Other: _____

THIS SECTION TO BE COMPLETED BY OFFICE STAFF

BP _____ HEIGHT _____ WEIGHT _____ SAT _____ PLS _____ TMP _____

General: _____

Head, ears, eyes, nose, throat: _____

Lungs: _____ Heart: _____

Lymph nodes: _____ Neurologic: _____

Abdomen: _____ Genitalia: _____

Vascular: _____ Breasts: _____