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.

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.

_____
Patient Signature (or Parent if Minor)

_____
Date

2474 SW Perkins Ave Pendleton, OR 97801 tel (541) 966.1001 fax (541) 966.1195 www.surgeonbower.com

NORTHEAST OREGON
SURGICAL CLINIC
Dr. Andrew Bower

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 heath 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 _____

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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) _____
_____
_____

How much **alcohol** do you drink a day? ☐Don't drink alcohol
☐___shots/day ☐____cans/day ☐____ounces/day

Do You use **tobacco?** ☐Yes ☐ No – ☐Don't Use Tobacco ☐Never smoked
If yes: ☐Cigarettes: ___packs/day ☐Cigars: __cigars/day ☐Chew/Snuff: ____cans/day

Do you drink **caffeine?** ☐Yes ☐No How much/day _____

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

HEALTH QUESTIONNAIRE (page2)

Name: _____

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 pertaining to this problem:

(x-rays, CT scan an MRI etc.…) ☐ Yes ☐ No

- Where and When?_____
- Why: _____

HEALTH QUESTIONNAIRE (page 3)

Name: _____

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
Ears/Nose/Throat:	earache, hearing loss, ringing in the ears, hearing aids, nose bleeds, hoarseness, throat pain, neck stiffness, lump or swelling in the neck
Cardiac:	chest pain of discomfort, artificial heart valve/stent, fast heart rate, Palpitations, high blood pressure, pacemaker
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 ☐No ☐ Yes : Where? _____
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: _____