Bridgeport Family Medicine

New Patient Forms

Newborn to 14 years old

Demographics

Today's Date _____

Patients Name: _____
Last First M.I.

Preferred Name (Nickname): _____ Pronouns:_____

Parents names: _____

Date of Birth _____ Age:_____ SSN:_____

Gender: _____Male _____Female _____Prefer not to answer

Primary Phone Number: _____ Cell/Home/Work

Secondary Phone Number: _____ Cell/Home/Work

Email Address:_____

Mailing Address:_____

_____

Emergency Contact Name: _____ Relation:_____

Emergency Contact Phone Number:_____

Preferred Pharmacy and Location: _____

_____

Insurance Information

Insurance Company:_____ Subscriber ID:_____

Guarantor Name(Primary PolicyHolder): _____

Guarantor Date of Birth:_____ Relation:_____

Mailing Address(if different from above):_____

_____

Guarantor Phone Number:_____

Allergies

Medication Allergy:____No____Yes
If yes, please list medication and reaction below:
_____

_____

_____

Food Allergy :____No ____Yes
If yes, please list which food(s) and reaction below:
_____

_____

Current Medications

Please list all medications that you are taking. Include all non-prescription medications, vitamins, or supplements.

Name of Medication	Dosage(i.e. Strength in mg)	Instruction(i.e.pills per day)

Pregnancy and Birth

Birth weight:_____ Birth length:_____

Age of mother at infant's birth: _____

Term at which baby was born: _____Full-term _____Post-term _____Preterm # of weeks:_____

Type of delivery: _____Vaginal _____Cesarean If cesarean, please state the reason:_____

Blood type of mom (if known):_____ Blood type of baby (if known): _____

Feeding source: _____Breastmilk _____Formula _____Both

Name of obstetrician (OB):_____

Hospital of delivery (cite, state): _____

Did mother use alcohol or tobacco during pregnancy? ____Yes ____No

Were there any medical problems during pregnancy? (e.g. diabetes, infections, high blood pressure, breech presentation, etc):

____Yes ____No If yes please explain:

_____

Were there any problems during labor? ____Yes ____No If so, what kind? _____

Were there any problems during the hospital stay (e.g. jaundice, prematurity, breathing difficulties, feeding difficulties, infections)?

____Yes ____No If so please explain:_____

Past Medical History

Please list previous surgeries and dates below:

_____

_____

_____

Do you now, or have you ever had?

☐ Diabetes	☐ Heart murmur	☐ Crohn's disease
☐ High blood pressure	☐ Pneumonia	☐ Colitis
☐ High cholesterol	☐ Pulmonary embolism	☐ Anemia
☐ Hypothyroidism	☐ Asthma	☐ Arthritis
☐ Migraines	☐ Emphysema/COPD	☐ Seasonal allergies
☐ Cancer (Type)_____	☐ Stroke	☐ Stomach/peptic ulcers
☐ Leukemia	☐ Epilepsy (seizures)	☐ Heartburn/GERD
☐ Psoriasis	☐ Cataracts	☐ Tuberculosis
☐ Anxiety	☐ Kidney disease	☐ HIV/AIDS
☐ Heart Problems	☐ Kidney stones	☐ Depression

Other medical conditions (please list):

_____

_____

_____

Are you established with any specialists (e.g. cardiologist, pulmonologist) to manage the above condition(s)? If so, please list below:

_____

_____

_____

Family History	
Illness:	Relationship to patient:
☐ Anemia	
☐ Anxiety	
☐ Cancer ☐ Breast cancer ☐ Ovarian cancer ☐ Endometrial/uterine cancer ☐ Colon cancer ☐ Pancreatic cancer ☐ Prostate cancer ☐ Gastric/stomach cancer ☐ Melanoma ☐ Other cancer	
☐ Diabetes	
☐ Glaucoma	
☐ High blood pressure	
☐ High cholesterol	
☐ Heart attack (M)	
☐ Stroke	
☐ Depression	
☐ Other mental illness (please list)	
☐ Other (please list)	

Preventative Care
Date and location of last physical exam (wellness visit):_____
Date of last dental exam _____
*Please provide the clinic with a current vaccination record for your child as soon as possible.

Child's School History:

Where does your child go to school?_____ What grade?_____

Attended a special class? ____Yes ____No

Any behavior problems in school? ____Yes ____No

Any academic problems? ____Yes ____No

If yes to any of the above questions, please explain.

_____

_____

_____

_____

Notice of Privacy Practices
Acknowledgement and Consent

I understand that Bridgeport Family Medicine will use and disclose health information about me. I understand that my health information may include health information both created and received by the practice. It 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, diagnosis, treatments, procedures, pprescriptions, and similar types of health related information. I understand and agree that Bridgeport Family Medicine 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.
- 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 understand I have the right to receive and review a written description of how Bridgeport Family Medicine will handle health information about me. This written description is known as the Notice of Privacy Practices and may be revised from time to time, and that I am entitled to receive a copy of any revision. I also understand that a copy of the most current version of the Notice of Privacy Practices will be posted in the reception areas. I understand I have the right to ask that some or all of my health information not to be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Bridgeport Family Medicine is not required by law to agree to such requests.

By signing below, I acknowledge that I have read and understand all the information included in this policy.

Patient/Patient Representative Signature Relationship (if not patient) Date

If you have any questions about this policy, please see a representative in our office. We appreciate the opportunity to serve you.

Rev 10/2022

Bridgeport Family Medicine

Financial Policy

The primary goal of our practice is to provide the best care to Oregonians of all ages. Since our practice has obligations that must be met, we ask that you agree and abide by our payment policies. Insurance coverage is an agreement between you and your insurance company for the payment of medical services. You are responsible for understanding your coverage benefits and guidelines for obtaining medical services. You are ultimately responsible for full payment of professional services, laboratory charges, and any additional costs associated with the visit.

Types of payment we accept are cash, check, Visa, Mastercard, and American Express.

Insured Patients: Please come to all appointments with the necessary insurance information and card(s), so we can bill the insurance in a timely and accurate manner. If patients do not have their insurance card upon check in and we are unable to verify coverage, patients will be considered a self pay patient or will have the option to reschedule.

Newborns: Please contact your insurance as soon as possible after the birth of your child. Most health plans will allow 30 days to add your newborn. Otherwise you may have to wait until an open enrollment period to add your child to the insurance policy.

Self Pay Patients: If you do not have proof of insurance, you will be considered a self pay patient.

- New Patient Consult- $200
- Office visit/Telemedicine- $150
- Wellness- $200
- Sports physical- $150

*Additional pricing available upon request

Copays: If your insurance policy has a copay, it is due at the time of service.

Collections: All balances are due within 30 days of receiving the first statement. Delinquent accounts more than 90 days past due, with no payments are subject to collections activity. You will be notified in writing prior to any action. It is the patient's responsibility to keep your contact information up to date. This includes but not limited to mailing address, phone number, and email address. This will ensure you receive your statements and are aware of your account balance.

Existing patients with delinquent accounts and/or accounts turned to a collections agency will have to pay 50% of their account balance or arrange a payment plan prior to having an appointment with a provider at Bridgeport Family Medicine.

Cancellation policy: We understand circumstances arise preventing you from coming to your appointment. Please call 24 hours in advance to cancel or reschedule your appointment. This will allow another patient in need of care to be seen. If a patient has three missed appointments, the patient may be discharged from the practice. Appointments that are missed or canceled under 24 hours from the appointment start time are considered a no show. A no show will result in a $50 fee. Patients may be asked to pay an outstanding no show fee prior to being seen for their next appointment.

If you arrive over ten minutes past your appointment start time, we will ask you to reschedule your appointment.

Labcorp Laboratory: Bridgeport Family Medicine uses Labcorp Laboratory for all lab services. Bridgeport Family Medicine does not guarantee coverage of lab work. It is your responsibility to notify the provider and staff if your insurance requires the lab work to be sent to a different laboratory. If the information is not provided in a timely manner and the clinic is unable to cancel the order, the balance will become your responsibility. Any billing questions related to lab work done by Labcorp Laboratory will need to be addressed with the Labcorp Laboratory Billing Department.

We understand patients could encounter challenging financial times. It is our desire to keep your medical expenses at a manageable level. If you find yourself in a financial bind and you are unable to pay your statement in full when due, please contact our office to discuss setting up a payment plan.

As a guarantor of the patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of Bridgeport Family Medicine. I authorize my insurance benefits to be paid directly to the provider. I authorize the provider to release any information required for this claim. I have read and understand this payment policy.

_____

Signature DOB

_____

Printed Name

_____

Date

_____

Child(ren)

_____

_____

HIPAA Right of Access Authorization: (For Family Members and Friends)

As required by privacy laws, Bridgeport Family Medicine will not disclose your protected health information without your consent.

I, _____, hereby authorize my health care and medical services providers and payers to disclose and release my protected health care status or health care information with:

Name/Relationship/Phone Number:

_____

_____

_____

Name of Patient/Individual Giving this Authorization:

_____

Date of Birth

Signature of the Individual Giving this Authorization:

_____

Date

- ☐ OK to leave a detailed voicemail
- ☐ OK to leave a detailed email
- ☐ Do not leave detailed messages

Bridgeport Family Medicine

Authorization to Release Medical Information TO Bridgeport Family Medicine

Patient Name _____**Date of Birth**_____ **Phone Number** _____

I authorize information to be released from::

Name/Address: _____

_____

Telephone: _____ **Fax:** _____

Please send general records to (for protected information inclusion, see below):

Bridgeport Family Medicine
16083 SW Upper Boones Ferry Road #130 Portland, Or 97224
Tel: 503-603-9087 Fax: 503-603-9122

Purpose of release (Please check appropriate box):

☐ Changing primary care physician/clinic **effective** _____

☐ Other (specify)_____

*** There is a charge to copy for personal use and legal purposes. Charges are waived when sent to another provider*.

Type of information to be released:

☐ GENERAL medical records –excluding protected records: (see below)
Records will be limited to two years of information including labs and x-rays unless otherwise requested

☐ SPECIFIC information or dates only: _____

_____

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 (patient initials needed when 14 years and older):

____AIDS/HIV Test Results ____Genetic Testing
____Alcoholism/Drug Abuse Treatment ____Mental Health Diagnosis/Treatment (including ADD/ADHD)

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and authorization is necessary to participate in the research study and receive research related treatment.

This authorization is valid for **six months** and may be revoked by the patient (orally and in writing) at any time prior to **six months**. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in the written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke authorization, please send a written statement to Bridgeport Family Medicine , 16083 SW Upper Boones Ferry Rd #130 Portland, Or 97224 and state you are revoking the authorization.

Patient Authorization to Release Information

Patient Signature_____ **Date** _____

Parent/guardian signature if patient is under 18 y.o_____ **Date** _____