New Patient Forms

15 years and older

Demographics

Today's Date ____________________

Patients Name: ____
Last First M.I.

Preferred Name (Nickname): _______________________________________ Pronouns:__________________

Date of Birth _____________________ Age:___________ SSN:_______________________

Gender: _____Male _____Female ______Prefer not to answer

Primary Phone Number:__________________________ Cell/Home/Work

Email Address:____

Mailing Address (including zip code):____

____

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)**

Social History

Occupation:____

Relationship status:____

Do you use contraceptives? _____Yes _____No If so, what kind?______________________________

Partners: _____Female _____Male _____Both

Do you currently drink alcohol? ____Yes ____No

If so, how many drinks per week?_______

Do you currently smoke or chew tobacco? ____Yes ____No

If so, how many packs per day?_______

Did you regularly use tobacco in the past? ____Yes ____No

If so, how long did you smoke/chew? __________ Previous packs per day:__________ Quit date:______________

Do you currently use recreational drugs? ____Yes ____No

If so, what kind?____
Did you regularly use drugs in the past? ____Yes ____No

If so, what kind? ____

How long did you use?_______________ Have you used IV drugs? ____Yes ____No

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	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 (MI)	
☐ Stroke	
☐ Depression	
☐ Other mental illness (please list)	
☐ Other (please list)	

Preventative Care

Date and location of last physical exam (wellness visit):______________________________

Date of last Tdap vaccine (tetanus shot):______________________________

Date of COVID-19 vaccine(s): ______________________________

Date of last influenza vaccine (flu shot):______________________________

Date of last dental exam: ______________________________

Date of last colonoscopy (if applicable): ______________________________

If female:
Date and location of last Pap smear: ______________________________

Date and location of last mammogram:______________________________

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, prescriptions, 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

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 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 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

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** ________________