PATIENT INFORMATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Have you previously been seen by Mason Harrison FNP-C? _____________ Yes _______________ No

Patient Name	Today's Date	Date of Birth	Gender	Age
Parent if Patient is a Minor				
Patient's Social Security Number		Oregon Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Primary (Best) Telephone Number May we leave a message? (If blank the assumption is Yes) ___________ NO		Secondary Telephone Number		
Occupation		Employer's Name		
May we contact you at work? (If Blank the assumption is Yes)				
Race: Decline _____ White _____ American Indian/Alaska Native _____ Nat Hawaiian/Pac Isl _____ Asian _____ Black/African American _____ Or Other _____ Ethnicity: Hispanic or Latino _____ Not Hispanic or Latino _____ Declined _____				
Emergency Contact Name/Number and Relationship				
We now have Patient Portal Please list email address ____				
Preferred Pharmacy:				
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name		Telephone		
Address	City	State	Zip	
Primary Insurance Company	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Relation to Patient		
Insurance ID No.:				
Is a referral required: YES NO		Is a copay required: YES NO		
Secondary Insurance Company	Claim Address			
Subscriber's Name	Subscriber's Date of Birth	Relation to Patient		
Insurance ID No.:				
Is a referral required: YES NO		Is a copay required: YES NO		
Were You Injured on the Job? YES NO		Have you Informed Your Employer? YES NO		
Date of Original Injury:				
Worker's Compensation Carrier Name		Address:		

Patient Name:____

Chief Complaint today:____

Height:		Weight:			
Past Medical History		**ILLNESS/INJURY: Please check if you have ever had:**			
Yes	No		Yes	No	
		AIDS			Gallstones
		Anemia			Hepatitis
		Anxiety Disorder			High Cholesterol
		Arthritis			High Blood Pressure (Hypertension)
		Asthma			Trouble Sleeping (Insomnia)
		Back Pain			Kidney Disease
		Bipolar			Liver Disease
		Cardiac Arrest			Migraines
		Chest Pain			Heart Attack (Myocardial Infarction)
		COPD			Nausea
		Chronic Pain			Osteoporosis
		Deep Vein Thrombosis			Peptic Ulcer
		Depression			Psoriasis
		Diabetes Type I			PTSD
		Diabetes Type II			Sleep Apnea
		Diverticulosis			Stroke
		Dizziness			Thyroid Disorder
		Eczema			Vomiting
		Esophageal Reflux			Well Child Exam
		Fibromyalgia			

OPERATIONS: List names and dates of all operations you have had ☐ **None**

Year	Name of Operation	Type of Anesthetic, if Known Complications

Have you ever had a blood transfusion? ☐ Yes ☐ No Date: ___________

List any hospital admissions or medical conditions not list above:

____

MEDICATIONS: Please list all drugs you take and their dosages. ☐ **None**

Drug	Dosage	Drug	Dosage

ALLERGIES TO MEDICATIONS: Please list type and reaction ☐ **None**

Name of Drug	Reaction	Name of Drug	Reaction

Patient Name:____

Diagnostic Testing: Please list type and Year it was last done			**☐ None**
Name Procedure/Labs	Year	Where was this performed?	Ordering Provider
Last blood draw/Labs:			
Colonoscopy:			
Mammogram:			

FAMILY HISTORY: Has any member of your family ever had the following?

Which family member(s)?	Mother/Age	Father/Age	B=Brother/Age S=Sister/Age
Breast Mastectomy			
High Blood Pressure (Hypertension)			
Heart Disease			
Stroke			
Diabetes (Enter Type 1 or Type 2)			
Cancer			
Bleeding Disorders			
Mental Disease (anxiety, depression, etc)			
Drug or alcohol addiction (Enter “D” or “A”)			
Other:			

FEMALES ONLY: Date of last menstrual period? _______________

Status of Social History: MUST COMPLETE

Tobacco?	☐ Current Some days	☐ Current Everyday	☐ Former	☐ Never	Yrs Quit ________
Alcohol?	☐ Current Some days	☐ Current Everyday	☐ Former	☐ Never	Yrs Quit ________
Marijuana?	☐ Current Some days	☐ Current Everyday	☐ Former	☐ Never	Yrs Quit ________
Other?	☐ Current Some days	☐ Current Everyday	☐ Former	☐ Never	Yrs Quit ________

Type: _________________

MEDICARE – I request that payment of authorize Medicare benefits be made either to me or on my behalf to the above physicians for any services furnished by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named physicians any information regarding my Medicare claims under title XXVIII of the Social Security Act.

COMMERCIAL INSURANCE – I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim who performs the service. I understand that I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

The above information is true and correct.
Patient Signature (parent if patient is a minor) : ____

In the event of an emergency do you have an Advance Directive, POLST, or Health Proxy?
(If yes, Please make sure we have one on file)
Are you interested in getting information on one?

Mason Harrison, FNP-C

FINANCIAL POLICY

The following disclosures are made in compliance with the Federal Truth in Lending Law. River Rock Family practice, P.C. will extend credit to a patient with the understanding that:

Parent/Child The adult accompanying the child is responsible for payment at the time of service including copayment. The parent/guardian with whom the child resides is the person who will be billed for services rendered. We will not be involved in mediating financial arrangements between parents/guardians. We will bill insurance as stated below.

Regarding Insurance It is the **responsibility of the patient** to know what is covered and excluded from his/her plan. You will be asked to **present your insurance at each visit**. If this information is not provided, the balance will be the patient's responsibility. We ask that you **pay your copay at the time of service**. If this payment is not made by closing of the next business day a charge of $10.00 will be assessed. We accept all payments made from the insurance. If there is overpayment made from either the patient or insurance, there will be a refund generated.

Secondary Insurance We will submit claims to your secondary carrier as a courtesy. You are responsible for deductibles, co-pays, and any non-covered services provided. You are responsible for any balance after insurance (s) has cleared.

Usual and Customary Rates Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Private Pay We ask that our patients without insurance pay in full at the time of service. We offer a discount if full payment is made on the day of the visit. All charges are due and payable within 30 days from the date of the closing statement. If there is no payment made at that time, the patient has 60 days to pay off the debt until a monthly billing charge of $5.00 is charged.

Monthly Payments on Outstanding Balances If you are not able to pay your account in full at the time of service and need to make monthly payments, you will need to make a payment arrangement with our office. After this arrangement is made, the account will be turned over to our collection agency if it is not met.

Service Charges We reserve the right to apply a billing charge of $5.00 per month to your account for balances after 60 days. A fee of $25.00 will be assessed to your account for any checks returned due to non-sufficient funds. We will charge the patient $5.00 for forms filled out by the physician if not done at the time of service. This is to cover additional administrative costs. These amounts will not be billed to the insurance company. **We accept personal checks, money orders, VISA, MasterCard, and cash**.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read, understand and agree to the Financial Policy for River Rock Family Practice, P.C.

______________________________ ________________

Signature of Responsible Party Date

Mason Harrison, FNP-C

ACKNOWLEDGMENT AND CONSENT

I understand that River Rock Family Practice, P.C. (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my health information may include information both created an received by the practice, 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, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that **This Practice 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; and
- 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 also understand that I have the right to receive and review a written descriptions of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I m entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By____ ____________________
(Patient) Date

OR

By____ ____________________
(Patient representative) Date

Description of Representative's Authority____

Mason Harrison, FNP-C

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

Patient name ____________________ Date of birth ____________

Authorization

I authorize ______________________________ to use and disclose a copy of the specific health
*(Name and address of individual/entity **releasing** information)*

information described below to ______________________________ for the purpose of:
*(Name and address of individual/entity **receiving** information)*

____

____

(specifically describe each purpose for disclosure)

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist: Please **initial** for release of records (**do not *check* spaces**)

_____ All pertinent medical records
_____ Laboratory reports/pathology reports
_____ Diagnostic imaging reports
_____ Most recent three (3) year history
_____ Physical therapy records
_____ Other (specify) ____________________
____
____
_____ This authorization is limited to the following treatment: ____________________
_____ This authorization is limited to the following time period: ____________________
_____ This authorization is limited to worker's comp claims for injuries of: ____________________

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Genetic testing information
_____ Sexually transmitted disease information
_____ Alcohol/chemical dependency diagnosis, treatment or referral information
_____ Mental health information
_____ Sexually transmitted disease information

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 law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

Patient information

You do not need to sign this authorization. Refusal to sign 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 the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to ____________________ (contact person) at ____________________ (address of person/entity disclosing information) and state you are revoking this authorization.

This authorization will expire on the earlier of ____________________ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Signature

I have read this authorization and I understand it.

______________________________ ____________
(Signature of individual or personal representative) *(Date)*

Description of personal representative's authority ____________________