LAKE GROVE
FAMILY MEDICAL CLINIC

16463 Boones Ferry Suite 100 · Lake Oswego, OR 97035
(503) 635-1350 Fax: (503) 635-8470

PATIENT REGISTRATION FORM

Please Print Clearly

PATIENT INFORMATION

First Name:	Last Name:	M.I.:	Date of Birth:
Mailing Address:	City:	State:	Zip:
Home Phone: Preferred ☐ Ok to leave detailed message? ☐	Cell Phone: Preferred ☐ Ok to leave detailed message? ☐	Email:	

Electronic Notifications: By selecting the checkboxes, I agree to receive text and/or email notifications from the clinic.
☐ EMAIL ☐ TEXT MESSAGING

Marital Status: Married Single Widowed Divorced Partnered	Would you like to join our online Patient Portal? YES ☐ NO ☐

Spouse's Name:	Driver's License Number:	State:

PATIENT EMPLOYER

Employer:	Work Phone:		
Address:	City:	State:	Zip:
Occupation:			

INSURANCE INFORMATION

Insurance Company Name / Claims Address:		
Policy Holder First Name:	Policy Holder Last Name:	Policy Holder Date of Birth:
ID Number:	Group Number:	Relationship To Patient:

IN CASE OF EMERGENCY

Name:	Phone Number:
Relationship To Patient:	

Signature of the Patient or Responsible Party:	Date:

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FINANCIAL POLICIES AND PROCEDURES

Welcome to Lake Grove Family Medical Clinic. Our goal is to make each and every person feel comfortable and confident that you are receiving the best medical care and that our policies are clearly outlined.

We strive to maintain good communications with our patients and we have outlined the following office guidelines for financial responsibility. Please take the time to read through the policies and sign and date below indicating your full understanding and agreement.

INSURANCE: Lake Grove Family Medical Clinic (LGFMC) will bill your personal or group health insurance for services rendered. It is the responsibility of the patient or guardian to provide the clinic with **current** insurance information at all times. We will verify the information from your card to what we have in our billing system with each appointment. If you do not have your insurance card, you will be asked to pay in full at the time of service. We must have proof of valid insurance on file. If your insurance changes at any time, please call the office and notify us as soon as possible to avoid delays and possible fees. We would also like to remind you that failure to provide current and correct insurance information may cause your claim to deny and become patient responsibility.

Lake Grove Family Medical Clinic (LGFMC) is not obligated to contact your insurance carrier for any information; we do this as a courtesy and remind you that you need to know your benefits as we can't possibly know every person's benefits in detail. Please be advised that insurance is **not a guarantee** of coverage OR payment and it is patient responsibility to know their insurance. This includes deductible amounts, co-pay/co-insurance amounts and any exclusion to your policy. ***Co-pays, deductibles and payment for non-covered services are due at the time of service.***

NOTE: Patients choosing to receive medical care for non-covered services outlined by their insurance policy agree to pay for said charges PRIOR to receiving treatment.

REFERRALS: It is the patient's responsibility to know IF their insurance company requires a referral and to contact their insurance carrier with any questions or disputes regarding their policy, covered treatments, amounts paid, etc.

DEDUCTIBLES, CO-PAYS, ACCOUNT BALANCES: *IF* you have a yearly deductible that has not been met, Lake Grove Family Medical Clinic (LGFMC) requires **a $100.00 - $150.00 deposit** (depending on your deductible amount) to be made on your account at time of service. You will be billed for the balance amount owed once your insurance has processed your claim.

A rebilling fee of $15.00 will be assessed to your account upon generating a 2nd statement for an unpaid account balance. A returned check fee of $35.00 will be assessed to your account for a bounced check.

PRIVATE PAY: Patients without insurance are expected to pay for their entire visit at time of service unless a prior arrangement has been made with the Billing Manager for payment arrangements.

MEDICARE / MEDICAID (OMAP): Lake Grove Family Medical Clinic (LGFMC) does not accept these insurances as we are not contracted with them. If you have this insurance, *please* notify us at once.

MVA RELATED: Patients are expected to pay for their entire visit at the time of service. Lake Grove Family Medical Clinic (LGFMC) does not bill auto insurance or Third Party claims.

WORKER'S COMPENSATION CLAIMS: Lake Grove Family Medical Clinic (LGFMC) accepts *new* Worker's Compensation Claims ONLY. In the event the work comp claim is not accepted, we require personal or group health insurance information with your registration.
Please provide us with the claim number, case worker name and phone number, and any other relevant information needed to process the claim. *IF* your claim denies, we will bill your personal health insurance and you will be liable for all patient responsibility balances and non-covered services. The account must be paid within 45 days once transferred to personal insurance.

DELINQUENT ACCOUNTS: Delinquent accounts are accounts that have an unpaid balance on them that is over 45 days old and may have been denied by insurance. While Lake Grove Family Medical Clinic (LGFMC) will work with your insurance company to resolve denied issues, the account is still your responsibility and needs to be paid in full before the 45th day from the date of service (before it is delinquent on the 45th day). These unpaid accounts may be assigned to a credit reporting agency and will be charged a $75.00 collections fee, which will be added to the past due amount.

MISSED/NO-SHOW APPOINTMENTS: By signing below, you agree to pay for any and all no-show appointments. The fees depend on the type of appointment that was no-showed and ranges from $50.00 for a blood draw, $100.00 for an office visit and up to $200.00 for a physical. This cannot be billed to your insurance and is 100% patient responsibility. ***We require a minimum of 24 hours notice to cancel or change your appointment, or the charges above will apply.***

PAYMENT ARRANGEMENTS: Please contact our Billing Manager, before your account becomes delinquent, if you require payment arrangements. Lake Grove Family Medical Clinic (LGFMC) requires a credit/debit card to be placed on the account, monthly payments will be debited, and a receipt sent to you. *IF* your card declines, we will contact you immediately and we will ask for another valid card to be placed on the account. There will be a reprocessing fee of $15.00 for the transaction. Payment must be made within 5 business days or it can be turned over to our collections process.

MEDICAL RECORDS/TRANSFER OF CARE: When you transfer care to another physician/provider or clinic, there are fees associated with printing your records, reviewing your records, and mailing your records to another facility. The records cannot be sent electronically or put on a CD or flash drive. The records fee is based on the Oregon fee schedule.

By my signature below, I acknowledge that I have read, understand, and agree to the above financial policies and agree to accept responsibility for payment in full on my account. A copy of this signature is as valid as the original.

I give *authorization* to Lake Grove Family Medical Clinic to release any medical information necessary to process my claims and further *authorize* payment for medical benefits to Lake Grove Family Medical Clinic.

_____

Printed Name of the Patient

_____ _____

Signature of the Patient or Responsible Party Date

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ACKNOWLEDGEMENT AND CONSENT

I understand that Lake Grove Family Medical Clinic (referred to below as "This Clinic") will use and disclose health information about me.

I understand that my **health information** may include information both created and received by This Clinic, may be in the form of written or electron 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 Clinic 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 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 effort 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 description of how This Clinic 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 Clinic, 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 am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Clinic'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 Clinic 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 for Lake Grove Family Medical Clinic.

_____

Printed Name of the Patient

_____ _____

Signature of the Patient or Responsible Party Date

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VERBAL RELEASE CONSENT FORM

I understand that Lake Grove Family Medical Clinic maintains records of my medical and billing information as part of my healthcare. Under the requirements of HIPAA, this information is not to be given to any other person without my permission.

By signing this consent, I authorize Lake Grove Family Medical Clinic to verbally release information as designated below, to the following individuals for the purpose of assisting with my health care and/or finances, unless otherwise noted. This verbal release form does not include hard copies and/or electronic copies of medical records.

Name	Relationship	Phone Number
☐ *All Medical Records (includes billing and appointment)*	☐ *Billing information only*	☐ *Appointment information only*

Name	Relationship	Phone Number
☐ *All Medical Records (includes billing and appointment)*	☐ *Billing information only*	☐ *Appointment information only*

Name	Relationship	Phone Number
☐ *All Medical Records (includes billing and appointment)*	☐ *Billing information only*	☐ *Appointment information only*

By **initialing** the spaces below, I specifically authorize the release of the following medical information, if such exists:

_____Mental Health	_____Worker's Compensation	_____Alcohol Dependency
_____HIV / STD	_____Motor Vehicle	_____Chemical Dependency

☐ **I <u>decline</u> to have my medical and/or billing information discussed with family or friends.**

This authorization will expire at the end of the calendar year in which it was signed.
I understand I have the right to revoke this authorization by written request at any time.

_____
Printed Name of the Patient

_____ _____
Signature of the Patient or Responsible Party Date

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of Lake Grove Family Medical Clinic, you have the RIGHT to:

- Be treated with courtesy and respect with appreciation of your individual dignity, and with protection to your need for privacy.
- Impartial access to healthcare treatment or accommodations regardless of age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- Prompt, reasonable response to care needs, questions, and requests:
    - Business Hours: Monday – Friday, 8am – 5pm
    - After hours: Calls received by the answering service will either be routed to the provider on-call *or* returned by office staff the next business day, depending on the nature/urgency of the call.
- Know who is providing healthcare services and who is responsible for your care.
- An interpreter if you do not speak English.
- Have another person present during examination and/or treatment, unless that person's presence compromises your or others' rights, safety, and health.
- Be given, by the healthcare provider, information regarding diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- Refuse any treatment, except as otherwise provided by law.
- Make an Advance Directive and appoint someone to make healthcare decisions for you if you are unable. If you do not have an Advance Directive, we can provide you with appropriate information.
- Receive a copy of a reasonably clear and understandable itemized bill, and upon request, to have the charges explained.
- Voice your concerns about the care you receive. If you have a concern or complaint, you may talk with your healthcare provider or the site manager. You may also email your concern to: shannon@lakegrovefamilymedical.com

As a patient, you have the RESPONSIBILITY to:

- Treat all clinic staff, other patients, and visitors with courtesy and respect. Be respectful of others' privacy and properties. Assist in the control of the noise, smoking, and number of visitors.
- Provide complete and accurate information, including your full name, mailing address, phone number, date of birth, insurance carrier, and employer when required.
- Provide complete and accurate information regarding your health, including present condition, past illnesses, hospitalizations, medications (including over-the-counter products and supplements), allergies and sensitivities, and any other information that pertains to your health.
- Be an active participant in your care.
- Report to your healthcare provider unexpected changes in your condition.
- Make it known whether you understand recommended treatment and what is expected of you, including whether you anticipate not following the prescribed treatments or are considering alternative therapies. Ask questions if you do not understand. You are responsible for outcomes if you do not follow the treatment plan.
- Provide complete and accurate billing information for claim processing and to pay bills in a timely manner in accordance with this clinic's Financial Policy.
- Keep appointments, be on time for your appointments, and notify the clinic as soon as possible if you cannot keep an appointment.
- Failure to comply with the above may lead to termination from the clinic.