TUALITY PHYSICIANS
FAMILY PRACTICE & URGENT CARE

Tuality Physicians
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Urgent Care/ Chiropractic Registration Date:

Legal Name: _____ _____ _____
Last Name First Name Middle Name

Birthdate: _____ Social Security Number: _____ Gender: Male Female
MM/DD/YYYY ###-##-####

Address: _____ _____
Mailing Address Unit Number

_____ _____ _____
City State Zipcode

Phone: _____ _____
Primary Secondary

Email: _____

Contact Preference: Primary Secondary Email Text Message **Opt in- required*
Would you like text message appointment reminders? Yes No
Would you like to sign up for the patient portal? Yes No

Marital Status: Single Married Separated Divorced Widowed Other

Demographics

Race:
American Indian/Alaskan Native Asian Black/African American Native American/Pacific Islander White Other

Ethnicity: Hispanic/Latino Not Hispanic/Latino Other

Today's Appointment

Visit Reason: _____ _____
What is the reason for your visit today? *How did you hear about us?*

Primary Care

Do you have a primary care provider? Yes No If yes, who is your provider? _____

Are you changing primary care providers? Yes No If yes, why? _____

Emergency Contact

Contact: _____ _____ _____
Name Relationship Phone

Billing

Are you the insurance card holder or are you covered under another person's policy? I am the card holder Other
Please provide the contact information if you chose other:

_____ _____ _____
Name Date of Birth Phone number

_____ _____ _____
Address State Zipcode

Medical Conditions

Do you have any medical conditions that may affect your treatment? Yes No
Please list any conditions that may affect your treatment: _____
_____

Allergies

Are you allergic to any medications? Yes No

Please list allergies and reactions: _____
_____
_____

Do you have any allergies to: Eggs Tapes Latex Iodine Solution

Medications

Please list of your medications with name, dose and frequency. _____
_____
_____

**you may also bring photos of your medication bottles*

Preferred Pharmacy and Location: _____

Social History

Alcohol
Do you consume alcohol? Yes No
If yes: How Much: _____ How Often: _____ What age did you start/quit: _____

Tobacco
Do you use tobacco? Yes No
If yes: What type: _____ How much: _____ How Often: _____
When did you start: _____ When did you stop: _____

Substance Abuse **This information is confidential and will only be used for medical purposes*
Have you ever used illegal substances? Yes No
Do you still use illegal substances? Yes No

Do you use recreational marijuana? Yes No

Policies and Authorization

I have an Advance Directive on file: Yes No I would like a copy of the privacy policy: Yes No

Financial Policy: Patients are responsible for all charges for medical services. As a service to you, we will bill the insurance carriers with whom we are contracted with to a maximum of 2 carriers. Co-payments are collected at the time of service. Account balances not covered by your insurance are due within 30 days unless prior arrangements are made with the billing office. Established patients with a delinquent balance will be expected to remit payment prior to their next service. If you are unable to pay, your appointment may be rescheduled.

Workers Compensation: Claims will be filed in accordance with applicable laws. Forms must be filled out with all required information within 10 days of our initial treatment. Patients are responsible for payment for services rendered if a claim is denied, or if the 10 day filing limit expires.

Medical Records: Will be provided without charge to physicians whom you are referred by Tuality Physicians, PC and to your insurance plan for claim repayment. There is a charge for all other outgoing medical records, pursuant to ORS 192.563. All medical record requests must be prepaid prior to being processed and payment is the responsibility of the patient or guardian. Tuality Physicians, PC will process medical record requests within 30 days as prescribed by the State of Oregon.

Authorization: I, Patient/Legal Guardian, hereby consent to and authorize all treatments that may be considered necessary or advisable by the health care provider. I authorize Tuality Physicians, PC to contact the emergency contact person above and speak to them regarding my current addresses and phone number. I authorize Tuality Physicians, PC to release to my insurance company any information acquired in the course of treatment, in accordance with applicable law and with Tuality Physicians, PC patient privacy policy. (If you do not want test results to be released to your insurance company, you must pay for it out of pocket and ask your physician or nurse practitioner to "flag" the test so it will not be sent). I also authorize release of information to physicians and business associates necessary to carry out treatment, payment or healthcare operations. I agree that I am fully responsible for all expenses incurred, and hereby assign to Tuality Physicians, PC any and all insurance benefits for services rendered by Tuality Physicians, PC. I understand insurance coverage is a relationship between the insured and their insurance company. I accept financial responsibility for payment for charges incurred. Tuality Physicians, PC will attempt to file claims in a timely manner. I agree that I am responsible for payment for charges if claims are denied due to lack of information, or if payment is denied due to Tuality Physicians, PC not being provided with current insurance information. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. Responsibility for payment of treatment related to work injuries shall be governed by applicable laws. This authorization shall continue and be in full force and effect until revoked in writing.

Patient Name: _____ _____ _____
Last Name First Name Date of Birth

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

Acknowledgement of Receipt of Privacy Practices: I acknowledge and agree that I have reviewed and, if desired, received a copy of Tuality Physicians, PC's Notice of Privacy Practices posted at the front desk. *You may decline to sign this acknowledgement.*

_____ _____
Signature Date

_____ _____

Printed Name Relationship to Patient

CLINIC USE ONLY: Tuality Physicians, PC made good faith efforts to obtain the above referenced individual's written acknowledgement of the receipt of the Notice of Privacy Practices, but was unable to because Patient Refused Language Barrier Other Reason