orchidhealth
Exceptional, local healthcare

Greetings,

Welcome to Orchid Health! Our Medical Clinics were founded several years ago with the belief that our state's rural communities deserve to have accessible, high quality healthcare that is local, comprehensive, and takes the time to address what matters most to you.

Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge. Included is a Medical Records Release form, which allows us to request your past medical records prior to your first visit. We ask that you complete this form and mail it back to us or drop it off at our clinic as soon as possible. This will allow our providers to best prepare for your visit.

Additionally, your previous medical records must be received and reviewed prior to the prescription of any controlled substances. A Controlled Substance Agreement, which allows for random urine drug screening, must be signed before the prescription of controlled substances by Orchid Health providers.

In order for us to best serve you:

1. **Please check in at the clinic fifteen minutes prior to your scheduled appointment time.**
2. **Please bring the bottles of any current medications you are taking.**
3. **Please bring your insurance card and your ID with you to your visit.**
4. **If you need to cancel or reschedule your visit please provide us with 24 hours notice.**

In Oakridge, we are located on Highway 58, right near the Pharmacy.
In Estacada, we are located on the High School Campus, just to the right of the High School.

We look forward to meeting you!

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ORCHID HEALTH REGISTRATION FORM

(Please print)

Name: _____ Today's Date: _____ Gender: Male/Female/Other

First - Middle - Last

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name: _____

Former Name: _____ Marital Status: Married/Single/Divorced/Separated/Widowed/Partner

Date of Birth (mm/dd/yy):_____Social Security Number: _____

Home Phone: _____Mobile Phone: _____Work Phone: _____

Email: _____Preferred communication method: _____

Mailing Address: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Current Medical Provider/Primary Care:_____

Preferred Language: _____

Race/Ethnicity: (You can choose more than one if appropriate) ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino or Spanish Origin ☐ Other _____

INSURANCE INFORMATION

(please bring your insurance card to our receptionist)

Please indicate primary insurance type: _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PERSON Financially Responsible for Bills and Payment:

Name: _____ Best Phone Number: _____

Mailing Address: _____ City: _____ State: _____ ZIP Code: _____

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CONSENT FORM

Consent for Treatment: I consent to medical treatment of medical services performed or prescribed by the attending or the consulting medical providers at Orchid Health, and I agree to the performance of treatments or procedures which are considered necessary, routine, or advisable. An example of some treatments performed at Orchid:

- **Routine physical exams, including sports physicals**
- **Early detection, diagnosis and treatment of illness and injury treatment of minor injuries**
- **Assessment and management of chronic health conditions**
- **Age appropriate reproductive health**
- **Routine lab tests and Immunizations**
- **Health education, counseling, and wellness promotion**
- **Prescription medications if appropriate**
- **Behavioral health services**
- **Referral for health care services not provided by Orchid Health**

Authorization of Payment: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive. I also authorize release of any medical records necessary to allow the insurance company to pay for these services, within the guidelines of the HIPAA (Privacy) Laws. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If I do not have an active insurance, I agree to pay for services at the time they are received.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice is provided the first time I receive services from Orchid Health and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities, and I agree to abide by these guidelines. This form can be found on our website under patient forms, and is available at the clinic upon check-in.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to local Hospital Networks to Access Health History Information: I authorize the release of my historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call and Text I consent to receive calls and/or texts from Orchid Health for my protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Patient or Authorized Representative Name (Please print) _____

***If authorized representative please state relationship to patient* _____**

Signature _____ Date _____

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MEDICAL RECORDS RELEASE

Patient Name _____ **Former Name (if any)** _____

Current Address _____ **D.O.B.** _____

_____ **S.S.#** _____

City, State, Zip

Best Contact Phone _____

I Authorize Information Released FROM: (please print)

Clinic/Doctor's Name: _____
Address: _____
City, State, Zip:_____

Please Send My Records TO: (fax preferred)

Orchid Health Wade Creek
535 NE 6th Ave.
Estacada, OR 97023
Fax: (503) 630-8551
Phone: (503) 630-8550

Orchid Health Oakridge
47815 Highway 58
Oakridge, OR 97463
Fax: (541) 782-5823
Phone: (541) 782-8304

Purpose of Release

❒ **Establishing New PCP** ❒ **Sharing Health Information (from Consultant/Specialist)** ❒ **Personal Use** ❒ **Legal**

Type of Information To Be Released

❒ **Complete Medical Records** ❒ **Include Mental Health Records** ❒ **Include Confidential Records/HIV or other**

❒ **Include Records relating to Drug or Alcohol Treatment:**_____

❒ **Other (specify):** _____

This authorization will expire one year from the date of the signature below.
I understand that I can change my mind about this authorization at any time by writing to the health care provider or to Orchid Health, but that any information already transferred will remain in our Confidential Medical Record System.

I also understand that:

- **I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.**
- **Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information if it is relevant for consultation, or if you request we transfer your records to another location.**
- **I am allowed to receive a copy of this Authorization.**

Patient or Authorized Representative Name (Please print) _____
(*If authorized representative please state relationship to patient)*

Signature _____ **Date** _____

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COMMUNICATION PREFERENCES

Patient Name (last, first, middle): _____ Date of Birth:_____

Personal Communication Methods:

As our patient, we may need to communicate with you outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

OK to leave medical information on home phone: YES NO

OK to leave medical information on mobile phone: YES NO

❑ **I would like to sign up to communicate ONLINE through the PATIENT PORTAL.**

My email address is: _____

Authorization to Disclose Information to Others:

Without specific permission, we will not release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

I give permission to release the following information to the individuals listed below:

- ❑ **All health information about me created or received by Orchid Health, including medical records, case or medical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.**
- ❑ **All health information except for: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.**

Name	Relationship	Phone Number

TERM: This authorization will remain in effect for a period of one year. I can revoke this authorization in writing (at any time) as described in the Orchid Health Notice of Privacy Practices.

Signature _____ Date _____