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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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MINOR CONSENT FORM

Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age except for family planning, sexually transmitted disease services, and certain mental health services. ORS 109.610, ORS 109.640, ORS 109.675.

I understand the following types of services are offered through Orchid Health:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Management of Chronic Health Conditions
- Age appropriate reproductive health
- Routine lab tests, Immunizations
- Prescription medications
- Mental health services
- Referral for health care services not provided by Orchid Health

I have read and fully understand the above information, have asked questions about anything not clear to me. I understand that I may revoke this consent at any time.

I (parent/legal guardian) _____ give permission for my child, _____, to receive medical care at Orchid Health.

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. These 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.

Authorization of Payment:
Parent or Guardian: I _____assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and also authorize release of any medical records necessary to facilitate my treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. 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.

Parent/Guardian Signature _____ Date _____

Relationship to Minor: _____

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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.

Parent/Guardian Signature _____ Date _____

Relationship to Minor: _____

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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

Permission for non-guardian to consent for child's medical treatment (if patient is under 15 y/o):

- ❑ I give permission for the above listed individuals to provide consent for treatment on my behalf and to accompany the minor patient to their medical appointments.

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.

Parent/Guardian Signature _____ Date _____

Relationship to Minor: _____

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PATIENT RIGHTS AND RESPONSIBILITIES

Our goal is to provide the HIGHEST QUALITY of care for our patients. We respect and value you, and have created this document to help you understand what to expect from us, and what we expect from you.

You Have the Right To:

- Exercise these rights without regard to sex, age, economic status, educational background, race, color, religion, national origin, sexual orientation, gender identity, marital status, or the source of payment for care.
- Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand.
- Have privacy during care discussion, counseling & treatment.
- Personally review your medical records in the presence of a health care professional.
- Know the name and qualifications of staff providing your care.
- Know your diagnosis, health problems, test results, the potential advantages and risks of treatment, procedures, and medications in language you can understand.
- Expect that all services, treatment and counseling techniques will take place with your informed consent.
- File a complaint regarding any aspect of Orchid Health. Those who file complaints will be free from retribution.
- Have another individual present in the exam room with you, if you so desire.
- Request that another Orchid provider administer your care.
- Be treated from a culturally appropriate perspective.
- Receive quality medical care from a qualified provider.

You Have the Responsibility To:

- Treat Orchid staff with consideration, respect and dignity. Threats to any staff member will result in immediate termination of your care.
- Understand that your lifestyle does affect your health and take an active part in your health care.
- Follow the agreed upon treatment plan. If you choose not to follow or are unable to follow the treatment plan, it is your responsibility to inform your medical provider.
- Provide accurate and complete personal contact and insurance information as well as information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your health care.
- Communicate with your provider so that you understand a medical course of action and what is expected of you during the course of treatment.
- Observe Policies and Procedures that are for the safety and consideration of all patients and staff such as:
    - Request Prescription (Rx) refills in a timely manner. Contact your pharmacy, mail order pharmacy, or our office no less than 72 hours before your Rx is due to be filled.
    - Schedule appointments for CONTROLLED Prescriptions one week in advance
    - Arrive 15 minutes prior to your scheduled appointment time.
    - Call to cancel/ reschedule your appointments 24 hours in advance if needed.
    - Have proof of insurance and if applicable, your copayment, at the time of your appointment.