Patient Registration Form

Stayton Family Practice

1375 N 10th Ave Stayton, OR 97383 • Phone: (503) 769-2641 • Fax: (503) 769-3797

Patient Information

First Name	M.I.	Last Name	
Preferred Name	Date of Birth	Sex	SSN

Race: (check one)
☐ Decline to Answer ☐ Asian ☐ Native Hawaiian/Pac. Islander ☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Other

Ethnicity: (check one)
☐ Decline to Answer ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status	Primary Language

Mailing Address		
City	State	Zip

Home Phone	Work Phone	Cell Phone	Preferred Phone: (check one) ☐ Home ☐Work ☐Cell
Fax Number (if applicable)	Email Address		

Preferred Method of Communication ****Please only check one**** **Not all methods are currently available**

☐Mail ☐Phone ☐Email ☐Fax ☐Text Message ☐Secure Patient Website

☐ *Check here if same as above* Guarantor Information: (Person who is financially responsible)

First Name	M.I.	Last Name	Sex	Date of Birth	SSN
Mailing Address	City	State	Zip	Marital Status	
Home Phone	Work Phone	Cell Phone	Preferred Phone: (check one) ☐ Home ☐Work ☐Cell		
Relationship to Patient	Email Address				

Emergency Contact Information:

First Name	Last Name	Relationship to Patient
Contact Number	Alternate Contact Number	

Preferred Pharmacy Information:

Pharmacy Name	General Location (city and/or street name)

For Office Use Only:	*PC:*		*Initials*	*Date*
*Date Rcv'd:*_____		*Reg. Info*	_____	_____
		Facesheet	_____	_____

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Name:_____

Please complete the information below or supply us with a copy of your insurance card(s), both front & back:

☐ *Check here if you do not have insurance* **Primary Insurance Information:**		
Name of Insurance Company	**ID/Policy Number**	**Group Number**
Address of Insurance Company	**Do you have a co-pay?** ☐ No ☐ Yes - amount_____	**Phone Number**
Policy Holder (person carrying insurance)	**Policy Holder's Date of Birth & SSN**	**Relationship to Patient**

Secondary Insurance Information: (if applicable)		
Name of Insurance Company	**ID/Policy Number**	**Group Number**
Address of Insurance Company	**Do you have a co-pay?** ☐ No ☐ Yes - amount_____	**Phone Number**
Policy Holder (person carrying insurance)	**Policy Holder's Date of Birth & SSN**	**Relationship to Patient**

Please complete the information below if you are seeing us due to an on-the-job injury:

Workers' Comp Insurance Information: (if applicable)	
Name of Insurance Company	**Claim Number (if known)**
Claims Address for Insurance Company	
Name of Claims Adjustor (if known)	**Phone Number for Claims Adjustor (if known)**

Please complete the information below if you are seeing us due to an automobile accident:

Automobile Insurance Information: (if applicable)	
Name of Insurance Company	**Claim Number**
Claims Address for Insurance Company	**Date of Accident**

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Name:_____

Personal Health History

(Please fill out your Health History information as accurately as possible. This information is a confidential record)

Have you ever had the following? Check all that apply

AIDS ☐	Blood Transfusion ☐	Gastric Ulcer ☐	Hiatal Hernia ☐	Mitral Valve Prolapse ☐
Alcoholism ☐	Bronchitis ☐	Genital Herpes ☐	Inguinal Hernia ☐	Mononucleosis ☐
Anemia ☐	Cancer (what kind) ☐	Genital Warts ☐	HIV ☐	Mumps ☐
Anorexia ☐	_____	GERD ☐	High Cholesterol ☐	Osteoporosis ☐
Anxiety ☐	Chickenpox ☐	Glaucoma ☐	High Blood Pressure ☐	Pneumonia ☐
Irregular Heart Beat ☐	Chlamydia ☐	Goiter ☐	Erectile Dysfunction ☐	Rheumatic Fever ☐
Arthritis ☐	Depression ☐	Gonorrhea ☐	Irritable Bowel ☐	Scarlet Fever ☐
Asthma ☐	Diabetes Type I ☐	Gout ☐	Kidney Disease ☐	Stroke ☐
Back Pain ☐	Diabetes Type II ☐	Hearing Loss ☐	Kidney Infection ☐	Thyroid Disease ☐
Bipolar Disorder ☐	Drug Addiction ☐	Heart Attack ☐	Kidney Stone ☐	Tuberculosis ☐
Bladder Infections ☐	Eczema ☐	Heart Disease ☐	Liver Disease ☐	Whooping Cough ☐
Legally Blind ☐	Emphysema ☐	Hemorrhoids ☐	Measles ☐	
Blood Disorder ☐	Epilepsy ☐	Hepatitis ☐	Migraines ☐	

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all medications and supplements you take regularly (if necessary, attach additional sheet of paper)

Medication	Dose	Frequency (how often)	Prescribing Physician (or state if over the counter)

Please list all medication allergies and the reaction you have. ☐ **No Known Drug Allergies**

Allergic To:	Reaction	Allergic To:	Reaction

Social History: (circle your answer)

Do you smoke? **Never** **Quit** – when? _____ **Yes** – how much/how often? _____

Do you use smokeless tobacco? **Never** **Quit** – when? _____ **Yes** – how much/how often? _____

Do you drink alcohol? **Never** **Quit** – when?_____ **Yes** – how much/how often? _____

Do you use illegal drugs? **Never** **Former** **Yes** – what kind, how much/how often? _____

Do you use caffeine? **No** **Yes** – what kind/how often? _____

How much exercise do you get? **Sedentary** **1-2 times/month** **1-2 times/week** **3-4 times/week** **nearly every day** **daily**

Do you have a living will or advance directive? **Yes** **No** (if yes, please supply us with a copy for our records)

Are you Adopted? **Yes** **No**

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Name: _____

Family Health History:

Has any blood relative had any of the following? Be as specific as possible: for example "maternal grandmother"

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Alcohol Abuse			Epilepsy		
Allergies			Glaucoma		
Anemia			Heart Disease		
Asthma			High Cholesterol		
Blood Disorder			High Blood Pressure		
Cancer – what kind			Kidney Disease		
			Migraines		
Depression			Stroke		
Diabetes Type I			Thyroid Disease		
Diabetes Type II			Tuberculosis		

Women Only:

Menstrual Cycle

Age your period began: _____

Menopause: **No** **Yes**, since age _____

How many days do your periods last? _____

Length of entire cycle: _____

Menstrual Flow: **Light** **Medium** **Heavy**

Do you spot between periods? **No** **Yes**

Date your last period started: _____

Birth Control Method (circle all that apply)

Virgin Abstinence None

Natural Family Planning Withdrawal

Condoms Foam/Gel Diaphragm

IUD Pill Patch Nuvaring Depo

Vasectomy Tubal Hysterectomy

Essure Implanon

Pregnancies

Have you ever been pregnant? **No** **Yes**

How many children have you had? _____

Are they all living? **No** **Yes**

Have you had a miscarriage? **No** **Yes**

If yes, how many? _____

Have you had an abortion? **No** **Yes**

If yes, how many? _____

What is your reason for transferring care to Stayton Family Practice?

_____

_____

If you are in need of an appointment right away, what do you need to be seen for?

_____

_____

How did you hear about Stayton Family Practice?

☐ Yellow Pages ☐ Referred by a patient (patient's name)_____

☐ Web Search ☐ Other (please specify)_____

_____ Initial

By initialing here I acknowledge that I have had the opportunity to read a copy of **Stayton Family Practice's Notice of Privacy Practices** and I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I understand that I have the right to revoke this consent at any time by giving written notice to Stayton Family Practice. I also understand that I do not have to initial this space.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stayton Family Practice or my insurance company to release any information required to process my claims.

_____

Signature Date

Effective April 14, 2003

Notice of Privacy Practices

Stayton Family Practice

1375 N 10th Ave Stayton, OR 97383 • Phone: (503) 769-2641 • Fax: (503) 769-3797

This notice describes how medical information about you may be used and/or disclosed, and how you can get access to this information. Please review it carefully.

Our Commitment to Your Privacy

Stayton Family Practice (SFP) understands that the medical information about you and your health is personal, and we are committed to protecting it. We create a record of the care and services you receive from our clinic in order to provide you with quality care. SFP is required by law provide you with this Notice of Privacy Practices describing our legal duties concerning your PHI.

The law requires us to:

- Make sure that medical information is kept private.
- Provide you with this Notice of Privacy Practices.
- Follow the terms of this Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI):

The following categories describe different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We may also provide your PHI to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you.

Payment: We may use and disclose your PHI to obtain payment for your health care services. For example, obtaining approval for advanced imaging services may require that your relevant PHI be disclosed to the health plan.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of your physician's practice. These uses and disclosures are necessary for administration and to ensure that all of our patients receive quality care. For example, we may disclose your PHI to medical school students that see patients in our office. We may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders: We may use or disclose PHI to contact you to remind you that you have an appointment for treatment or medical care at our office.

Health-Related Benefits and Services: We may use or disclose your PHI to tell you about health-related benefits or services that may be of interest to you. For example we may offer a new service to patients with a certain condition. Our staff may contact you directly based on your PHI to offer you this new service.

Individuals Involved in Your Care or Payment for Your Care: We may use or disclose your PHI when talking with a friend or family member who is involved in your medical care at our office. We may also use or disclose your PHI when interacting with someone who helps pay for your care. **If you do not want us to make these disclosures, you must notify us in advance.**

To Avert a Serious Threat to Health or Safety: We may use or disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of others. Any disclosure; however, would only be to someone able to help prevent the threat.

Public Health Risks: We may use or disclose your PHI for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
- To report abuse, neglect or domestic violence. As required or authorized by law

Law Enforcement: We may use or disclose your PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of crime if, under certain limited circumstances, we are unable to obtain the person's consent
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our office
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Special Situations: We may use or disclose your PHI without your authorization in the following situations. These situations include:

- Health Oversight Activities – Examples include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits and Disputes – Only in response to a court or administrative order
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Military, Veterans and National Security – As required by military command or authorized federal officials
- Workers' Compensation
- Inmates or Individuals in Custody of a Law Enforcement Official – We may release PHI to the correctional institution or officials when necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES OF SPECIALLY PROTECTED INFORMATION:

Oregon and Federal law provide additional confidentiality protections in the following circumstances:

- HIV – In Oregon, healthcare providers generally may not release the identity of a person tested for HIV or the results of HIV-related testing without your specific consent and you must be notified of this confidentiality right.
- Drug & Alcohol – These records are specially protected and typically require your specific consent for release under both Federal and State law.
- Mental Health – These records are specially protected in some circumstances and typically require your specific consent for release under both Federal and State law.
- Genetic Information – Genetic information is specially protected and typically requires your specific consent for release under both Federal and State law.

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding the use and disclosure of your PHI:

Right to Inspect and Copy: You have the right to inspect and copy your PHI that may be used to make decisions about your care. Usually this includes medical and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

To inspect and copy your medical information that SFP uses to make decisions about you please contact our medical records department at (503) 769-2641. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility

- To request an amendment, please contact the SFP Privacy Officer for a form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.
- We may deny your request to amend information that:
    - Was not created by us
    - Is not part of the medical information kept by or for our office.
    - Is not part of the information which you would be permitted to inspect and copy.
    - Is accurate and complete.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we have made of your PHI in the previous six years, beginning April 14, 2003. You are not entitled to an accounting of disclosures made for the purposes of treatment, payment and health care operations; disclosures you authorized; disclosures to you; incidental disclosures; disclosures to family or other persons involved in your care; disclosures to correctional institutions and law enforcement in some circumstances; disclosures of limited data set information; or disclosures for national security or law enforcement purposes.

To request an accounting of disclosures from SFP, please contact the SFP Privacy Officer to request a form.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example you could ask that we not use or disclose information about a surgery you had.

Your practitioner is not required to agree to your request. If the practitioner believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional. If your practitioner does agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, please contact the SFP Privacy Officer to request a form.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications please contact the SFP Privacy Officer for a form.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice please ask at our reception desk.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the reception area of each of our offices. The notice will contain on the first page, in the top left corner, the effective date.

COMPLAINTS:

If you believe that your privacy rights have been violated, you may direct your complaint to the SFP Privacy Officer in writing. Please contact our office to request a form. If we cannot resolve your issue, you also have the right to file a written complaint with the US Department of Health and Human Services, Region X, Office for Civil Rights, 2201 6th Avenue, Ste. 900, Seattle, WA 98121.

We will not penalize you or retaliate against you in any way for filing a complaint.

OTHER PERMITTED USES AND DISCLOSURES OF PHI:

Other uses and disclosures of your PHI not covered by this notice or the laws that apply to us will only be honored with your written consent. If you provide us with permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

PRIVACY OFFICE AND CONTACT PERSON:

If you have any questions about this Notice of Privacy Practices or wish to object or complain about any use or disclosure as explained above, please contact the SFP Privacy Officer as listed below.

Stayton Family Practice
Attn: Privacy Officer
1375 N 10th Ave
Stayton, OR 97383
(503) 769-2641
info@staytonfamilypractice.com

STAYTON FAMILY PRACTICE

Committed to Community Care

New Patient Controlled Substance Policy:

Our goal at Stayton Family Practice and Jefferson Medical Clinic is to safely improve function and quality of life. In certain cases, this requires the use of controlled substances including narcotic pain medication, sedatives, stimulants and addictions. Unfortunately, there is a high potential for tolerance, dependence, and side effects, therefore, prescribing of such medicine is tightly regulated and must be carefully monitored by our clinic. Our providers are under no obligation to prescribe controlled substances to you. Failure to adhere to policy may be grounds for discontinuation of medication and/ or dismissal from the practice. Please review the following requirements for the prescribing of controlled substances:

-No new patients will be given a prescription for narcotic medication or controlled substance on the first visit.

-In order to initiate controlled substances within the practice, providers must have the medical records from prior prescribing providers

-The new provider may or may not choose to continue prescribing the controlled substance after gathering all necessary information for decision-making

-Controlled substances will only be initiated with direct patient evaluation

-Pain control may first be attempted with non-controlled medications/methods prior to initiation of controlled substances

-If the patient does not need palliative comfort care, a referral to pain management specialist will likely be considered to determine the need for a controlled substance prescription

-A screen for risk of abuse/misuse will be completed prior to prescribing controlled substances for long term use

-Urine toxicology screening will be performed prior to initiation and during long term controlled substance use

-Only your preferred provider will manage your controlled substances.

Hopefully you read and abide by the requirements we listed. Thank you from the staff of Stayton Family Practice.

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