PAM RATHBONE, WHCNP PC
KARL MAGSARILI, MD PC
MARCUS CORNWALL, DO PC

Monterey HEALTH CENTER

6975 SE LAKE RD
MILWAUKIE, OR 97267
PHONE: 503.905.2526
FAX: 503.905.2545

Date:_____

Name:_____
Appointment Date:_____
Appointment Time:_____am/pm
Scheduled with: _____

Welcome to Monterey Health Center. We appreciate the opportunity to partner with you for your medical care. To allow our staff to efficiently review your administrative information prior to your medical appointment, we ask that you arrive 15 minutes early and bring the following items with you:

- One form of legal photo identification (i.e. Driver's license). This is required to help prevent health care fraud.
- Your insurance card(s) for any medical coverage current for your appointment.
- Completed new patient forms enclosed or found on our website under "Patient Information".
- Your co-payment if one is required by your medical insurance policy at the time of service

Our providers enjoy their patients and the challenge of addressing their health care concerns. We try very hard to keep within the confines of the appointment schedule. For this reason, if you will be more than fifteen minutes late for an appointment, please call our office at 503-905-2526 to reschedule your reserved time. Appointments that are cancelled or rescheduled with less than 24 hour notice may incur a cancellation/reschedule fee.

The forms found on our website or enclosed with this letter have specific functions.

- The ***Patient Profile & History*** and ***Financial Arrangements & Assignment of Benefits*** forms allow us to bill your insurance coverage on your behalf and explain Monterey Health Center's financial policies.
- The ***Health Information Authorization*** form allows us to accurately communicate with you regarding your healthcare needs. Our Notice of Privacy Practices are on our website or may be requested in our office to take home and read at your leisure.
- The ***Authorization to Release Information*** form will allow other medical offices to forward their documentation to us for review. If you have seen other physicians within the past three years, it is extremely helpful to have their medical records for reference.
- The ***Prescription History Consent*** form allows us to electronically send prescriptions to the pharmacy of your choice and is a safer, faster, easier way to get your prescriptions filled. Please contact your pharmacy directly for all prescription refill requests. All requests require a 72 hour notification.

We want to use your time with us wisely; your attention to the new patient forms and requested information will help us better understand and address your medical concerns. If you have any questions either prior to your appointment or after you have established with our office, please do not hesitate to contact our office so that we can assist you.

Sincerely,

Monterey Health Center Providers and Staff

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PATIENT PROFILE

Patients Full Name:_____ DOB:_____Sex: M F

Address:_____City/State:_____ Zip:_____

Home Phone:_____Alternate #:_____SS#:_____

For call-backs, appointments & results etc. I authorize Monterey Health Center to contact me in the following manner:
☐ All forms of contact are acceptable ☐ Leave detailed message on home# ☐ Mail info to my home
☐ Leave message w/call back # only at home ☐ OK to call and/or leave detailed message on work/cell#_____

Employer:_____Occupation:_____Marital Status: M S D W

Employee Status (Please circle one): FT PT N/A Student Status: FT PT N/A Referred By:_____

Name of Emergency Contact:_____ Relation to Patient:_____Phone:_____

PERSON RESPONSIBLE FOR ACCOUNT (if other than above)

Name:_____Relationship:_____DOB:_____

Address:_____City/State:_____Zip:_____

Phone:_____Employer:_____Employers Phone:_____

SS#_____

PRIMARY INSURANCE COMPANY

Insurance Company:_____Phone: _____

Address:_____City/State:_____Zip:_____

Name of Insured:_____DOB:_____ID#:_____Group#:_____

Primary Care Physician:_____Phone:_____

SECONDARY INSURANCE COMPANY

Insurance Company:_____Phone: _____

Address:_____City/State:_____Zip:_____

Name of Insured:_____DOB:_____ID#:_____Group#:_____

ASSIGNMENT OF INSURANCE BENEFITS & AGREEMENT TO PAY:

I have completed the above to the best of my knowledge. If the information changes, I will notify MHC at the above phone number. MHC is not liable for incorrect information. A cancellation fee will be charged for appointments missed or canceled within less than 24 hours notice. MHC has my permission to bill my insurance company. **I understand that it is my responsibility to make sure that the Provider I am seeing is covered under my insurance plan.** I understand that I am responsible for all unpaid claims by my insurance company, whether it is for the office visit or the labs draw. I also understand that I am responsible for any fees charged to patients that do not have insurance coverage. A billing charge of not less than $5 or more than $25 will be charged on any unpaid balances per month after 90 days.

_____ _____

Patient/Insured Signature Date

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PEDIATRIC & ADOLESCENT HEALTH HISTORY

Patients Full Name:_____ DOB:_____ Age:_____ Date:_____
Circle either: Male or Female
Was the child born full term or premature?_____
Were there complications during the child's delivery:_____
Has the child had chicken pox infection? Yes / No
Tetanus (date last given):_____ Pneumonia Vaccine:_____ Hepatitis B Vaccine:_____ Hepatitis A Vaccine:_____
Childhood health concerns:_____

Allergies to OTC/Prescription Medication or Supplements?	**Reaction to OTC/Prescription Medication or Supplements? (i.e. rash, hives)**

Child currently taking OTC/Prescription Medication or Supplements?	**Child had any hospitalizations or surgeries?**	**Date**

Does the child regularly see any medical specialists? (For example – cardiologist, endocrinologist, physical therapist, physical medicine specialist, podiatrist, naturopath, acupuncturist, massage therapist, psychologist, psychiatrist).

Name of Specialist	**Specialty**

Who is responsible for making medical decisions for the child?

Name:_____ Relation:_____ Phone Number:_____
Name:_____ Relation:_____ Phone Number:_____

Family History (list relation – for example – mom, dad, brother, sister, maternal grandfather):

Diabetes_____
Heart attack (what age?)_____
Other heart disease_____
High blood pressure_____
High cholesterol_____
Uterine/Cervical cancer_____
Ovarian cancer_____
Breast cancer_____
Prostate cancer_____
Colon cancer (age diagnosed)_____
Depression_____
Alcoholism_____
Drug abuse_____
Arthritis_____
Bleeding disorder_____
Osteoporosis_____
Stroke_____

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Seizures_____
Other_____

Health Factors/Social History

Are you in regular contact with anyone who smokes? Yes / No Are there smoke detectors in your home? Yes / No
Is there a history of abuse? No / Yes – (circle all that apply: physical, emotional, sexual)
Studies confirm that spiritual beliefs significantly impact health and healing. Do you have a specific religion?_____

_____

Current diet restrictions or preferences:_____
Current diet consists of (circle all that apply): Organic Fruit/Veggies Meat/Protein Processed Foods Sugar Fast Food
Caffeine use: Do you regularly drink any caffeinated beverages? Yes / No
Circle all that apply: coffee / tea / soft drinks – How much per day?_____
How many times a week does your child exercise:_____
Do you have pets in the home? Yes / No If yes, what kind of animals?_____
Are there firearms in or near the home? Yes / No (These need to be locked up and kept away from children)
Current Marital Status of Mom (circle one): Never Married / Married / Partner or SO / Divorced / Separated / Widowed – Since when?_____
Current Marital Status of Dad (circle one): Never Married / Married / Partner or SO / Divorced / Separated / Widowed – Since when?_____
Are mom and dad married to each other? Yes / No Please clarify if needed:_____
Who lives with the child at home (indicate relation)?_____
Occupation of Mom:_____ Occupation of Dad:_____

ADOLESCENT GIRLS ONLY:

(Interval means 1st day of one period until the 1st day of the next)
What was the first day of your last period: _____ Usual interval between periods:_____
Usual duration of your periods:_____ What product do you use? Tampons Pads Both Other
ANY bleeding between periods? Yes No Describe:_____

_____

Do you experience menstrual cramps? No Yes Are they (circle one): Mild Moderate Severe
Do they occur before, during or after your period?_____
Do you need to take pain medication for the cramps? No Yes If yes, specify medication:_____

_____

Do you experience PMS? No Yes Are your symptoms: physical emotional both
Please describe when you experience your symptoms:_____

_____

Any breast issues you would like to discuss?_____

CONTRACEPTION/SEXUALITY HISTORY

Are you currently using ANY birth control method? No Yes If so, what type:_____

_____

Do you currently HAVE, or have you HAD:

Genital Herpes: Yes No
Abnormal pap smear: Yes No
Genital warts (condyloma, HPV): Yes No
Infection in your tubes or ovaries: Yes No
Please describe any of the above conditions:_____

_____

Monterey HEALTH CENTER

HEALTH INFORMATION AUTHORIZATION

INDIVIDUAL PATIENT

Patient Name:_____ Social Security Number:_____

Legal Responsibility

☐ If you are 18 years old or older, are legally emancipated and/or are legally responsible for yourself as the patient, check this box.

☐ If you are a parent or legal custodian of the patient, check this box.

THE USE AND/OR DISCLOSURE

I understand that under HIPAA regulations (my) the patient's health information will be used by any health care provider who is involved with (my) the patient's medical treatment or services, health insurance plan, clinical or physician office staff and any medical billing clearinghouse who is involved with insurance claims fulfillment.

Under these new regulations one or more of the following people must be authorized by me to have access to (my) the patient's health information: spouse, other family members, friends, nurse or home aid, legal guardian or other person/organization who is not involved with my medical treatment, insurance plan, or payment. Please list below, the people/organizations that you authorize to have access to (your) the patient's information in case of incapacitation or as a matter of medical course:

1) Name:_____ Contact Phone_____

Address:_____ Relationship to the Patient:_____

Is there a limit to what we may disclose? If so please explain:_____

_____

2) Name:_____ Contact Phone_____

Address:_____ Relationship to the Patient:_____

Is there a limit to what we may disclose? If so please explain:_____

_____

CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to Monterey Health Center.

METHOD OF CONTACT

For call-backs, appointments & results etc. I authorize Monterey Health Center to contact me in the following manner:

☐ All forms of contact are acceptable ☐ Leave message w/detailed info on home #. ☐ Mail info to my home

☐ Leave message w/call back # only at home ☐ OK to call and/or leave message on work/cell #_____

STATEMENT OF UNDERSTANDING

I have reviewed this Authorization and understand that (my) the patient's health information will be used in accordance with this form and in accordance with the Notice of Privacy Practices (NPP) *Brief Version*, which is on the clinic website, as well as a copy was offered to me to read and/or keep. I further understand that a *Long Version* of the NPP is available to me upon request or downloadable from the clinic website.

By:_____ Date:_____

(Patient)

Or By:_____ Date:_____

(Patient's Representative)

Description of Representative's Authority:_____

Karl Magsarili, MD • Marcus Cornwall, DO • Pam Rathbone, WHCNP
6975 SE Lake Road, Milwaukie, OR 97267
Phone: 503.905.2526 Fax: 503.905.2545

AUTHORIZATION TO RELEASE INFORMATION

This document provides the authorization for the release of information and/or the request for information as indicated below. Do not sign this release unless it is complete in full and in your best interests. It is also understood that if the person or organization that receives your information is not a health care provider or health insurer the information may no longer be protected by federal regulations. You may inspect and/or have a copy of this authorization and the information being released if you request one.

Medical Records to be sent to:

Monterey Health Center
6975 SE Lake Rd
Milwaukie, OR 97267
Phone: 503.905.2526
Fax: 503.905.2545

Medical Records to be sent from:

_____
_____
_____
_____
_____

Please release the complete medical history and all records pertaining to the care of:

_____
Patient Name

_____
Address

_____
City State Zip

_____ _____
Date of Birth Social Security #

The following must be ***INITIALED*** by the requestor to be included in the use and or disclosure:

_____ Chemical Dependency Information
_____ Mental Health Information
_____ HIV or AIDS information
_____ Genetic Testing Information

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance here on. If not earlier revoked, or by other agreement specified below, this consent shall expire:

- ☐ Six months from date signed
- ☐ One year from the date signed
- ☐ Other (specify) _____

By:_____ Date:_____
(Patient)
Or By:_____ Date:_____
(Patient's Representative)
Description of Representative's Authority:_____

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Electronic Prescription Consent Form

Monterey Health Center is in the process of implementing ePrescribing in our office.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the Internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information – like drug interactions and your prescription history.

The benefit to you:

Less confusion over handwritten prescriptions or unclear phone calls

- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to drop off at the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Consent:

I agree that Monterey Health Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

_____

Patient Printed Name

_____ _____

Patient Signature Date

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Financial Arrangements & Assignment of Benefits

Financial Policy

We are committed to providing you with the best possible care. If you carry medical insurance, we are anxious to help you receive your maximum allowable benefits. We will be happy to help you process your insurance claim form for your reimbursement. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If you do not carry medial insurance, payment for services is due at the time service is rendered unless payment arrangements have been approved in advance by our staff. If you are a self-pay (without insurance), as a courtesy we provide a 25% discount off our services if payment is made in full at the time of service. A $100.00 retainer fee will be required before seeing the doctor and will be applied towards any remaining balance if you will not be paying the full balance of your visit the same day of service. We accept cash, checks, MasterCard or Visa.

Returned checks, as well as balances older than 30 days, may be subject to additional collection fees and interest charges. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice. Additional fees may also be added to any copay not presented at the time of service.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must realize, however that:

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our fees fall within the acceptable range of must companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage (such as 50% or 80%) of "UCR". UCR is defined as usual, customary, and reasonable.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, **PLEASE** don't hesitate to ask us. ***We are here to help you.***

Assignment of Benefits

By signing below, I authorize Monterey Health Center to bill my insurance on my behalf, and assign all benefits, if any, directly to Monterey Health Center (Practitioners: Karl Magsarili, Pam Rathbone, or Marcus Cornwall) that otherwise would be payable to me for services rendered. I authorize the use of my signature on all insurance submissions. This consent will continue indefinitely unless revoked by me in writing.

By signing below, I acknowledge that I have read and understand all information presented to me in this document.

_____
Patient Printed Name

_____ _____
Patient Signature or Guarantor if a minor Date

Description of Guarantor's Authority if a minor:_____