2700 SE Stratus Ave. Suite 304, McMinnville, OR 97128 ◆ (P) 503-434-6090 ◆ (F) 503-474-3306

Patient's Name:		Patient's Birthdate:	Patient's Sex:
Patient's former or previous names:			
Primary Care Provider and Phone Number:		Referring Provider and Phone Number:	
Home Phone Number	Cell Phone Number:	Patient's SSN:	Marital Status (circle one): Single Married Widow Divorced
Email Address:		**Carehome/Facility address and phone number:**	
Mailing Address:		City: State:	Zip Code:
Preferred Language:	Ethnicity and Race (circle one): White/Caucasian Hispanic/Latino American Indian Asian African American/Black Other:		
Preferred Communication Method (circle one): **Phone Call:** __ Cell Number or __ Home Phone **Text Message** **Patient Portal Message** **Email**			
Employment Status (circle one): Full Time Part Time Unemployed Self-employed Student Active Military Retired Disabled			
Employer:	Employer Address:		

Patient/Guardian Information if Under 18 years of age/Person consenting to treatment (Responsible Party):			
Parent/Guardian:	Address if different from above:	Date of Birth:	Relationship to Patient:

INSURANCE INFORMATION – PLEASE PROVIDE INSURANCE CARD TO THE RECEPTIONIST		
Primary Insurance Plan Name:		Policy Holder's Name:
Policy Holder's Date of Birth:	Relationship to Patient:	Policy Holder's Employer:
Insurance ID Number:		Group Number:
Secondary Insurance Plan Name:		Policy Holder's Name:
Policy Holder's Date of Birth:	Relationship to Patient:	Policy Holder's Employer:
Insurance ID Number:		Group Number:

Workers Compensation and/or Motor Vehicle Claim information			
Carrier Name:		Billing Address:	
Claim #	Adjuster Name:	Adjuster Phone Number:	Adjuster Fax Number:
Date of Injury:	Body Part	**Employer:**	

Acknowledgement of Receipt of Notice of Privacy Policy

HIPAA FORM

I acknowledge that I have been given Willamette Valley Clinic's Notice of Privacy Practices (Available at front desk).
I understand that if I have questions or complaints I may contact the facility Privacy Official.

Print Name of Patient: _____

Signature: _____ **Date:** _____

Authority to sign if not the patient: _____

****

Disclosure of Protected Health Information to Patients Family Members or Others

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the rights to agree, restrict or object to providing PHI to family members or other persons identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the medical record.

I am granting permission for Willamette Valley Clinics to release PHI concerning myself to:

(1) Name: _____

Relationship to myself: _____

(2) Name: _____

Relationship to myself: _____

Signature: _____ **Date:** _____

****

I give permission for the clinic medical staff to:

* Leave a message concerning lab and/ or test results on my voicemail or answering machine.

* Release my written prescription and/or samples to the following individual (s):

_____

Authorized person's name (s)

Signature: _____ **Date:** _____

2700 SE Stratus Ave. Suite 304, McMinnville, OR 97128 ◆ (P) 503-434-6090 ◆ (F) 503-474-3306

Patient Name:	Date of Birth:

Under the Health Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to family member or other persons identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the medical record.

The following designated parties have AUTHORIZATION to my health information, written physical prescriptions, and are my emergency contacts:

1. Primary Emergency Contact & Designated Party:	Relationship to Patient:	Phone Number:
2. Designated Party Name:	Relationship to Patient:	Phone Number:
3. Designated Party Name:	Relationship to Patient:	Phone Number:

Notice of Privacy Policy:	
Initial Here:	I acknowledge that I have been given Willamette Valley Clinic's of Privacy Practices (available at front desk). I understand that if I have questions or complaints I may contact the facility Privacy Official.

Insurance Signature on File and Assignment of Benefits	
Initial Here:	I request the payment of authorized insurance benefits be made on my behalf to Willamette Valley Clinics, LLC for any services furnished to me by clinic providers. I authorize any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim, this includes Medicare, Medicaid, private insurance, and other health plans.

Additional Authorizations and Acknowledgements	
Initial Here:	**Authorizations for the Release of Medical Information:** I consent to the treatment necessary for the patient named on this document. I authorize the release, via fax if necessary, of all medical records, including any and all records containing HIV, substance abuse and/or mental health, to the referring and family physician and to my insurance company, if applicable.
Initial Here:	**Assignment of Benefits:** In consideration of any and all medical services, care, drugs, supplies furnished by Willamette Valley Clinics, LLC and providers. I hereby irrevocable transfer to Willamette Valley Clinics, LLC, all insurance benefits due and payable to me and/or surgical services rendered by providers for whom Willamette Valley Clinics, LLC is authorized to charge and bill. I understand and agree (regardless of insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I will also pay all costs and expenses of collection. I hereby authorize electronic billing for all of my claims.
Initial Here:	**"No Show" Appointment Policy:** A "No Show" is when a patient does not show up or does not call to cancel at least 24 hours prior to the scheduled appointment. • All no shows will be documented in the patient's chart and the patient will be notified by letter. • If 3 missed appointments have occurred without proper notice you will be considered for termination from the practice. • When you are formally released from the office, the office will provide only emergency care for a period of 30 days.

2700 SE Stratus Ave. Suite 304, McMinnville, OR 97128 ◆ (P) 503-434-6090 ◆ (F) 503-474-3306

Clinic Communication	
Initial Here:	**Patient Portal Acknowledgement and Agreement:** I have been notified that once I log in to the Willamette Valley Clinics, LLC patient portal, I need to read the Rules and Regulations regarding the Patient Portal. I understand the dangers with online messaging between the clinic and me, and agree to the rules. I also agree to follow the rules displayed on the log in screen. I agree to follow any other instructions that the clinic may give me regarding the use of the portal. I understand messages from me to the clinic will become part of my medical chart. I agree with the information that I have been provided. Please provide email address below: • Email Address: _____
Initial Here:	I grant permission for reminders of upcoming scheduled appointments to be left on my answering machine or with an authorized designated party, and/or sent via email, text message, or post card to your household. Notification regarding the availability of pathology, laboratory, and etc. results may also be left on your answering machine or with a family member who answers the telephone at your residence. Actual results however will not be left on your answering machine, though they may be communicated to those you authorized as a designated party. If you provided a cell phone number in your contact information, we will contact you on your cell phone and, if needed, may leave a message (including, without limitation, email, voicemail and text message). If you choose to receive text messages, applicable carrier charges may apply.
Initial Here:	**Prescription (RX) Refills:** You will need to call your pharmacy for prescription refills, with the exception of controlled prescriptions (narcotics) that will need a physical prescription. The pharmacy will notify the clinic if additional approval is needed. Please allow 48 business hours for all refills. **We will not refill non-emergency and/or controlled prescriptions on a Friday, weekend, or holidays.**

Patient notification of received items/acknowledgments and agreements

I agree that all information is correct and I have given my consent to treatment and other items by initialing those sections.

Patient, Parent or Guardian's Signature: _____ Date:_____

A copy of this signature is a valid as the original and is in effect until I revoke it. I understand this form will not be updated at each but will be completed annually. I will be responsible to provide any demographic/insurance changes at time of visit.

Willamette Valley Neurology

Patient History

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____

Primary Care Physician: _____

Pharmacy Name: _____

Do you use any nicotine products? ☐ Yes ☐ No

(Cigarettes, cigars, pipe tobacco, snuff, chewing tobacco, Vaporizer) If yes, how many much per day? _____

Do you drink alcohol? ☐ Yes ☐ No If so, how much? _____

If you are a female, could you be pregnant? ☐ Yes ☐ No

Do you have any blood relatives (father, mother, brother, sister, son, daughter) with the following conditions?

☐ Alzheimer (Dementia) Which relatives? _____
☐ Diabetes Which relatives? _____
☐ Trouble Walking Which relatives? _____
☐ Headaches Which relatives? _____
☐ Heart Attack Which relatives? _____
☐ High Blood Pressure Which relatives? _____
☐ Multiple Sclerosis Which relatives? _____
☐ Epilepsy (Seizures) Which relatives? _____
☐ Stroke Which relatives? _____
☐ Tremor (shaking) Which relatives? _____
☐ Mental Illness Which relatives? _____

What medications are you taking? (Name, Dose and how often)

_____ _____

_____ _____

Please check any symptoms you have been having:

☐ Chest Pain	☐ Vomiting	☐ Headaches	☐ Nausea
☐ Fevers	☐ Bladder or Urine Problems	☐ Memory Problems	☐ Eye Pain
☐ Fatigue	☐ Rash and Skin Problems	☐ Numbness and/or Tingling	☐ Blurred Vision
☐ Weight Gain	☐ Back Pain	☐ Loss of Consciousness	☐ Weakness
☐ Weight Loss	☐ Neck Pain	☐ Difficulty with Hearing	☐ Seizures
☐ Dizziness	☐ Involuntary Movements	☐ Swallowing Problems	☐ Falling
☐ Ringing in Ears	☐ Speech Problems	☐ Depression	☐ Hallucinations
☐ Anxiety	☐ Difficulty with Walking	☐ Difficulty with Breathing	☐ Tremor

Have you had any of the following:

☐ Stroke ☐ Cancer ☐ High Blood Pressure ☐ Diabetes ☐ Heart Attack
☐ Ulcers ☐ Allergies to medications (which ones)? _____