Willamette Valley Clinics, LLC - McMinnville Surgical Associates
392 NE Norton Ln, McMinnville, Oregon 97128
Office: 503-434-6060 Fax: 503-472-8605

# PATIENT REGISTRATION

## Patient Information

Last Name: _____
First Name: _____
Middle Name: _____

Account # _____
Sex: _____ Date of Birth: _____
Social Security No.: _____
Address: _____

Zip: _____
City: _____ State: _____
Home Phone: _____
Work Phone: _____
Mobile Phone: _____
Marital Status: _____
Race: _____
Ethnicity: _____
Preferred Language: _____

## Emergency Contact Information

Name: _____
Phone: _____
Relationship to: _____

## Employer Information

Name: _____
Phone: _____

## Guarantor Information (to whom statements are sent)

Name: _____
Address: _____

Phone: _____

## Other

Patient Referred by: _____
Patient PCP: _____
Usual Provider: _____
**Email:** _____

## Primary Insurance Information

Insurance Plan Name: _____
Insurance Phone Number: _____
Claims Address: _____

## Policy Information

Patient's relationship to policy holder: _____
ID/Certification No.: _____
Policy/Group No.: _____
Issue Date: _____
Exp Date: _____
Co-pay Amount: $ _____
Co-insurance Percent: _____

Name: _____
Address _____

City: _____ State: _____
Social Security Number: _____
Date of Birth: _____
Employer: _____

## Secondary Insurance Information

Insurance Plan Name: _____
Insurance Phone Number: _____
Claims Address: _____

## Policy Information

Patient's relationship to policy holder: _____
ID/Certification No.: _____
Policy/Group No.: _____
Issue Date: _____
Exp Date: _____
Co-pay Amount: $ _____
Co-insurance Percent: _____

Name: _____
Address _____

City: _____ State: _____
Social Security Number: _____
Date of Birth: _____
Employer: _____

## Medication History Notice: Acknowledgement

Patient Name: _____ Date of Birth_____

I understand that my physician may need access to my medication history and may work in conjunction with my pharmacy and / or insurance carrier in order to provide accurate medical treatment.

√ _____ _____

Patient or Personal Representative Signature Date

**For Office Use Only**

- ○ Patient refused to sign
- ○ Patient unable to sign due to communication / language barrier
- ○ Patient unable to sign due to emergency situation
- ○ Other (please explain) _____

_____

_____ _____

Office Representative Signature Date

## ASSIGNMENT, RELEASE AND AUTHORIZED SIGNATURES

I understand the credit policy and agree to accept responsibility for full payment of my account. In the event of default of payment of my account, I understand and agree that I am legally liable for all costs of collection, including collection agency fees, reasonable attorney fees, court costs, and all other costs to collect this debt. Willamette Valley Clinics has retained and is under contract with a collection agency to handle delinquent accounts. All necessary legal action will be utilized to collect this debt if a default occurs.

I consent to 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. I agree to pay for all charges for treatment and understand that payment is due at the time of service. I further authorize and request insurance payments be made directly to the physician. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to the physician. I agree to notify this Clinic of any changes in insurance, address, and other information included on this form. I understand I am responsible for all charges not paid by my insurance company.

I have read, understand and agree to the above.

_____

√Signature of Responsible Party or Guardian Date

## Acknowledgement of Receipt of Notice of Privacy Practices

*Available at Check-In*

I acknowledge that I have been given Willamette Valley Clinic's Notice of Privacy Practices. I understand that if I have questions or complaints I may contact the Facility Privacy Official.

Printed Name of Patient: _____

Date: _____

Witness: _____

*Signature:* _____ Date: _____

Authority to sign if not the patient: _____

### Disclosure of Protected health Information to Patient's Family Members or Others

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to family members or other person indentified 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:**

Name: _____

Relationship to myself: _____

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 prescriptions and/or samples to the following individual(s):

_____

*Signature:* _____ Date: _____

## Willamette Valley Clinics, LLC

## Patient Financial Policy

**Patient Name:** _____ **Account #**_____ **Date** _____

Thank you for choosing Willamette Valley Clinics, a division of Capella Healthcare. We are strongly committed to providing you and your family with the best available medical care.

We are pleased to accept and bill your insurance we contract with, on an assigned basis subject to verification of your coverage. Please understand that your insurance plan is between you and your insurance company; therefore, Willamette Valley Clinics, LLC will not become involved in any disputes you encounter with your coverage or become engaged in litigation with your insurance company. You are fully responsible for any amounts not paid by your insurance.

We accept Cash, Check and most credit cards. You will be charged a $25.00 fee for any payments returned by your financial institution for non-payment.

Non-Insured Patients: Payment is due at the time of service unless previous payment arrangements are made. We offer a 40% prompt pay discount in our primary care clinics and a 50% prompt pay discount in our specialty care clinics when paid in full at the time of service.

Insured Patients: All out of pocket expenses including co-payments, deductibles and/or co-insurance are due at the time of service. It is your responsibility to provide us with your insurance information prior to receiving services. Verification of benefits is not a guarantee of payment and you will be responsible for any services considered non-covered by your insurance. If for any reason your insurance company does not cover services you received within (60) sixty days, the full amount billed will become your responsibility to pay immediately.

Worker's Compensation: If you were injured at work and want us to bill your employer's workers compensation carrier, we may need to get authorization from the carrier in order to treat you. If authorization is not obtained, we may not be able to provide services to you.

Motor Vehicle Accidents: If you were injured as a result of an motor vehicle accident and want us to bill motor vehicle insurance, we require a deposit of ½ of our fees prior to providing services. We will bill your motor vehicle insurance on an assigned basis. In the event we receive full payment from your auto insurance, we will refund the amount you overpaid. You will be responsible for any balances not covered by your auto insurance.

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable out of pocket expenses, are my responsibility.

| _____ | _____ | _____ |
|---|---|---|
| Date | Patient or Guarantor Signature | Printed Name |