CASCADE PHYSICIANS, P.C.

PATIENT INFO

Last Name:	**First Name:**	Middle Initial:
Preferred Name:	**Date of Birth:**	**Sex:**
Address:	Social Security #:	
City: **State:** **Zip:**	**Marital Status:** ☐Single ☐Married ☐Partner ☐Widowed ☐Divorced	
Primary phone: ☐Mobile ☐Ok to leave detailed message?	**Race:** ☐White ☐African American ☐Asian ☐Other ☐Hispanic ☐Native American ☐Refuse to Report	
Secondary phone: ☐Mobile ☐Ok to leave detailed message?	**Ethnicity:** ☐Hispanic ☐ Non-Hispanic ☐ Refused to Report	
Work Phone: Ext:	Employer Name and Address:	
Email:		
Do you have an Advanced Directive or POLST? ☐Yes ☐ No	Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Not employed	

EMERGENCY CONTACT

■ Patient Here

Last Name: First Name: MI:	☐Spouse ☐Partner ☐Friend ☐Child ☐Parent ☐Other:	
☐ **Okay to leave a detailed message with this contact** Phone 1:	Phone 2:	
Address (if different from patient):	Date of Birth:	

ADDITIONAL EMERGENCY CONTACT

■ Patient Here

Last Name: First Name: MI:	☐Friend ☐Child ☐Parent ☐Other:	
☐ **Okay to leave a detailed message with this contact** Phone 1:	Phone 2:	
Address (if different from patient):	Date of Birth:	

PRIMARY INSURANCE

Insurance Company Name:	ID Number:	Group Number:
Claims Address:	Claims Phone Number:	
Primary Subscriber Name (if different from patient): Date of Birth:	Relationship to patient: ☐Spouse ☐Partner ☐Parent ☐Other:	
Phone 1: Phone 2:	Social Security #:	

If you have more than one insurance plan, please make sure to provide that information to the office at the time of service.

PREFERRED PHARMACY

Pharmacy Name:	**Pharmacy Phone Number:**	Pharmacy Fax Number:
Pharmacy Address:	City, State, Zip:	

Payment is due at time of service. If patient is covered by insurance, the insurance company will be billed. It is your responsibility, however, to pay your portion at the time of the service. If necessary, please discuss other financial arrangements with our billing office. Finance charges will be assessed after 90 days. Visa and MasterCard are available for your convenience.

I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of amount due, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

SIGNATURE:

Patient Signature (or Guardian):	**Date:**
Whom may we thank for referring you?	Relationship:

CASCADE PHYSICIANS, P.C.

HEALTH QUESTIONAIRE

Date: _____

Name: _____ Date of Birth: _____ Age: _____
Last First Initial

Reason for today's visit: _____

PERSONAL HISTORY:

Have you ever had:	yes/no		yes/no		yes/no
Anemia	☐ ☐	**Kidney Disease**	☐ ☐	**Appendectomy**	☐ ☐
Arthritis	☐ ☐	**Liver Disease**	☐ ☐	**Other Surgery** (Please list):	
Diabetes Mellitus	☐ ☐	**Thyroid Disease**	☐ ☐	_____	
Gallbladder Disease	☐ ☐	**Seizure/Epilepsy**	☐ ☐	_____	
High Blood Pressure	☐ ☐	**Stroke**	☐ ☐	_____	
Heart Disease	☐ ☐	**Ulcer Disease**	☐ ☐	_____	

Have you ever smoked? Y / N **If you smoke now, how many cigarettes a day?** ____
Coffee/Tea? Y / N **Approx. how many cups do you drink per day?** ____
Alcohol? Y / N **Average drinks per day?** ____
Other Drug use? _____

Drug Allergies: _____

List any medications that you take on a daily basis:

_____ _____ _____
_____ _____ _____
_____ _____ _____

When was your last Tetanus immunization _____ **Pneumovax** _____

FAMILY HISTORY: (please list any family members with the following problems & age when diagnosed)

Cancer _____ Heart Attacks _____ Other: _____
Diabetes _____ Hypertension _____ _____

CURRENT HEALTH CONCERNS: (circle all recent problems)

Fevers/Chills
Anxiety/Depression
Sadness/Change in moods
Cough
Shortness of Breath
Chest Pain
Abdominal Pain
Blood in stool
Diarrhea/Constipation
Frequent/Painful Urination
Nighttime urination (>1)
Headaches
Joint Pain/Swelling
Swelling in feet
Loss of consciousness
Memory Problems
Rash/Itching/Changing Mole
Vision/Eye concerns
Weight Gain/Loss
Heat/Cold Sensitivity
Sexual Problems
other: _____
_____

WOMEN ONLY:

(number of)
Pregnancies _____ Last menstrual period _____
Deliveries _____ Age at onset of menstruation _____
Abortions _____ Date of last PAP smear _____ Any abnormal pap? Y / N
Miscarriages _____ Form of contraception (if using) _____
Other: _____

Patient signature: _____ **Dr. Initial:** _____

CASCADE PHYSICIANS, P.C.

Financial Policy

Patient Responsibility:

It is your responsibility to keep your demographic information up-to-date with us. This includes contact information and current insurance information. If you provide all necessary insurance information, we will bill the health plans with which our practice has contracts, as a courtesy to you. These include Medicare, Medicaid, Health Maintenance Organizations (HMO) and a number of Preferred Provider Organizations (PPO).

Your health insurance policy is a contract between you and your health plan. Please understand our office cannot accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. Whatever the outcome of your insurance claim, you are responsible for payment of your account. Please take time to review your health insurance policy. **If you have questions regarding your benefits or coverage, please call your insurance company as we do not have knowledge of your benefits.**

Co-payments, Deposits, and Past Due Balances:

Please come prepared to pay Copayments, Deposits, and Past-Due balances at the time of your visit.

- **You may be assessed a $15 administration fee if your copayment is not paid at the time of service.**
- **If you are uninsured, you will be required to pay a $150 deposit for the initial visit and $100 for each subsequent visit prior to rendered services.**

- **Checks returned by the bank will be assessed a $25 fee.**
- **Certain procedures and/or services may require payment at the time of service.**
- **If you believe you have an overpayment on your bill, please contact the business office.**

Insurance Billing and Benefits

As a courtesy, we will bill your primary and secondary insurances for you, if you are a guarantor or a dependent on the plan. However, primary responsibility for the account is yours. We are contracted with the majority of commercial insurances, as well as Medicare and some Medicaid. A list of contracted insurance plans is available at www.cascadephysicians.com

Please be aware there is a possibility that some or perhaps all of the services provided may be non-covered services or may not be considered medically necessary by your health plan. You are responsible for understanding your insurance benefits. Cascade Physicians, P.C. is not responsible for and has no knowledge of your plan benefits. If you have concerns that your insurance will not fully cover scheduled services we recommend that you contact your insurance plans for an estimate of benefits prior to receiving those services in order to avoid unexpected out-of-pocket costs.

If we refer you to a specialist or a service or prescription needs prior-authorization, we will attempt to obtain one for you. However, we cannot guarantee that service will be covered.

Payment Arrangements:

Payment is due upon receipt of your statement. Special arrangements may be made for patients having higher out-of-pocket costs. If you are not able to pay in full within 30 days of receiving your statement, please contact the billing department: 503.242.9814.

Cancellations and No Shows

Appointments must be cancelled at least 24 hours before the scheduled appointment. Late cancellations and/or missed appointments may be assessed a fee.

Payment is due upon receipt of your statement. Special arrangements may be made for patients having higher out-of-pocket costs. If you are not able to pay in full within 30 days of receiving your statement, please contact the billing department: 503.242.9814.

In the event of refusal to sign this Financial Policy, the office reserves the right to decline care.

I have read, understand and agree to this Financial Policy.

x_____ _____

Signature of Responsible Party Date

_____ _____

Printed Name Date of Birth

CASCADE PHYSICIANS, P.C.

ACKNOWLEDGMENT AND CONSENT

I understand that Cascade Physicians, P.C. (referred to below as "This Practice") will use and disclose health information about me.

I understand that my health information may include information both created and received by the Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and mu rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ _____
Patient signature Date

-OR-

By: _____ _____
Patient Representative Date

Description of Representative's Authority: _____

For administrative use only:

We are unable to obtain the patient's written acknowledgement of our notice of Privacy Practices due to the following reasons:

☐Patient declined to sign ☐Other: _____

_____ _____
Signature of staff member Date

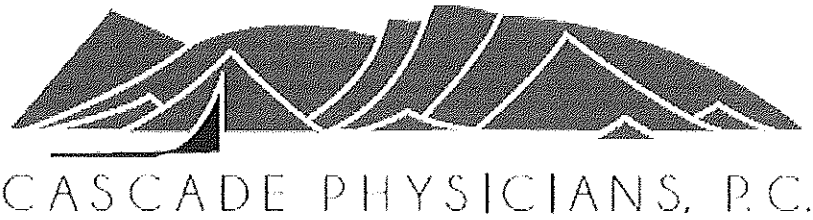
updated: 3/1/2016

CASCADE PHYSICIANS, P.C.

Patient Rights and Responsibilities

As a patient and/or his/her legal representative of Cascade Physicians, you have the right to:

- Receive considerate, respectful and compassionate care in a safe and secure environment that is free of all forms of discrimination, abuse or harassment, regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
- You have the right to be informed of the name, identity and professional status of your primary healthcare provider, as well as the name, identities, professional status and professional relationship of other healthcare providers and team members involved in your care.
- Communications in a language and manner in which you understand. Interpreters will be provided when necessary.
- Have another person present during examination and/or treatment, unless that person's presence compromises your or others rights, safety, and health.
- To be told by your health care provider about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcomes of treatment in terms you can understand. You have the right to give written informed consent before any non-emergency procedure begins.
- Within the confines of law, review your medical records. All communications and records pertaining to your care will be treated as confidential.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatment.
- Agree to or refuse to participate in research projects
- To make an advanced directive and appoint someone to make healthcare decisions for you if you are unable. If you do not have an advanced directive, we can provide you with appropriate information
- Expect reasonable continuity of care
- Receive and examine an explanation of charges for services rendered, as well as receive detailed information regarding charges received.
- You, and others whom you elect, have the right to participate in decisions about your care, your treatment, and services provided, including the right to refuse treatment to the extent permitted by law.
- You have the right to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your health care provider or the site manager. You may also email your concern to: compliance@cascademed.com



Patient Responsibilities:

As a patient and/or his/her legal representative of Cascade Physicians, you have the responsibility to:

- To provide complete and accurate information, including your full name, address, telephone number, date of birth, insurance carrier, and employer when required.
- To provide complete and accurate information regarding your health, including present condition, past illnesses, hospitalizations, medications (including over-the-counter products and supplements), allergies and sensitivities, and any other information that pertains to your health.
- Be an active participant in your care.
- You are expected to make it known whether you clearly comprehend a proposed treatment plan and what is expected of you, including whether you anticipate not following the prescribed treatments or are considering alternative therapies. Ask questions if you do not understand. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
- Inform and report unexpected changes in your condition to the responsible practitioner in a timely manner
- You are expected to treat all clinic staff, other patients, and visitors with courtesy and respect. Be respectful of others and their properties while in Cascade Physician facilities. Assist in the control of the noise, smoking, and number of visitors. Cascade Physicians does not allow weapons of any kinds on the premises.
- Provide complete and accurate billing information for claim processing and to pay bills in a timely manner.
- Keep appointment, be on time for you appointments and notify your physician as soon as possible if you cannot keep your appointments.
- Failure to comply with the above may lead to termination from the practice.