Welcome to Hillsboro Pediatric Clinic LLC
PATIENT REGISTRATION FORM FOR PATIENTS 18 YRS OR OLDER

Thank you for selecting us for your healthcare provider!
In order to serve you, we need the following information. **Please print.**

PATIENT INFORMATION				
Last Name:	First:	Middle:	❑ Male ❑ Female	Date of Birth:
Race: ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Asian ❑ White, not Hispanic ❑ Black or African American ❑ Hispanic ❑ Decline to Answer				

ADDRESS				
Street Address:	Apt. #:	City/Town:	State:	Zip Code:
Mailing Address (If different):	Apt. #:	City/Town:	State:	Zip Code:

Phone 1:	❑ Home ❑ Cell ❑ Cell Mom ❑ Cell Dad	Phone 2:	❑ Home ❑ Cell ❑ Cell Mom ❑ Cell Dad	
Phone 3:	❑ Work ❑ Other:	Phone 4:	❑ Work ❑ Other:	
Employer:	Social Security Number:	Email Address:		
	Preferred Language:	Need interpreter? ❑ Yes ❑ No		

Resides with: ❑ Mother ❑ Father ❑ Both Parents ❑ Foster Parent ❑ Legal Guardian ❑ Other:

EMERGENCY CONTACT	
Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

BILLING INFORMATION	
❑ Private Pay (No Insurance)	❑ OHP: Tuality Health Alliance/ Care Oregon/ DMAP *(circle one)* **Client ID #:** _____
❑ INSURANCE (Primary) Effective Date: _____/_____/_____ Insurance Name: _____ Subscriber Name: _____ DOB: _____/_____/_____ Policy #: _____ Group #: _____ Copay: $ _____	❑ INSURANCE (Secondary) Effective Date: _____/_____/_____ Insurance Name: _____ Subscriber Name: _____ DOB: _____/_____/_____ Policy #: _____ Group #: _____ Copay: $ _____

Notice of Privacy: I acknowledge that I have access to a complete copy of Hillsboro Pediatric Clinic LLC's (HPC) "Notice of Privacy Practices," which describes in detail how my medical information may be used and disclosed and how I can get access to my health information.

Pharmacy: I hereby authorize HPC to electronically send prescriptions to a participating pharmacy of my choice. HPC may electronically receive information regarding my prescription history, drug interactions, prior authorization requirements or required substitutions.

Pharmacy Name: _____ Location: _____

Patient Centered Primary Care Home: As a Patient Centered Primary Care Home ("Medical Home"), HPC is committed to providing the highest quality patient centered care. HPC care will be delivered by a team of health care professionals including Physicians and Nurse Practitioners, Registered Nurses, Medical Assistants and other skilled staff. I will be encouraged and supported as I become involved in my care. The goal is to ensure that my healthcare needs are coordinated so that I have the best possible health outcome.

_____	_____	_____	_____
Signature	**Print Name**	**Relationship to Patient**	**Date**

Patient or Legal Guardian Consent to Treat and Consent to Use and Disclose Protected Health Information

Hillsboro Pediatric Clinic LLC
503-640-2757
FAX 503-640-9753

CONSENT TO TREAT

Patient's Full Legal Name: _____

Patient's Date of Birth: _____

I hereby authorize the physicians and other providers employed by the Hillsboro Pediatric Clinic, LLC ("Clinic") to provide such medical service, either regular or emergency, as may be necessary for the above patient.

In the event this child is in need of medical treatment and I or another legal guardian are unable to bring him/her in for treatment, I hereby authorize the following person(s) to seek medical treatment for this child and to discuss PHI to the extent you deem necessary to provide such treatment **(write name and relationship to patient):**

1) _____ _____
Name of non-legal guardian authorized to bring patient in for treatment — Relationship to patient

2) _____ _____
Name of non-legal guardian authorized to bring patient in for treatment — Relationship to patient

3) _____ _____
Name of non-legal guardian authorized to bring patient in for treatment — Relationship to patient

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

With my consent, the Clinic may use and disclose protected health information ("PHI") about this patient to carry out treatment, payment and healthcare operations ("TPO"). I understand the Clinic's Notice of Privacy Practices contains a more complete description of such uses and disclosures.

I have been provided a copy of the Notice of Privacy Practices, and I have a right to review the Notice prior to signing this consent. The Clinic reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, Hillsboro Pediatric Clinic LLC at 445 East Main Street, Suite 100, Hillsboro OR 97123-4084 or fax your request to Privacy Officer at fax (503) 640-9753.

The Clinic has my consent to mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment and flu shot reminder cards or billing and other correspondence that is marked Personal and Confidential.

I understand the Clinic will also telephone me at the numbers I have provided.

The Clinic may leave a message at my home or other designated location with the person who answers, or on voice mail, or by sending a fax related to the items checked below.

- ❑ CARE AND TREATMENT
- ❑ APPOINTMENTS
- ❑ TEST RESULTS
- ❑ INSURANCE AND BILLING
- ❑ REFERRALS
- ❑ DO NOT LEAVE A MESSAGE

I have the right to request that the Clinic restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions; but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Clinic's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, Hillsboro Pediatric Clinic, LLC may decline to provide treatment to the above patient.

_____ _____
Signature of Patient or Legal Guardian — Date

_____ _____
Print Name of Patient or Legal Guardian — Relationship to Patient