Welcome to Hillsboro Pediatric Clinic LLC
PATIENT REGISTRATION FORM

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

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐ Male ☐ Female	Birth Date:

Race: ☐American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐Native Hawaiian or Other Pacific Islander ☐ White, not Hispanic ☐ Hispanic ☐ Decline to Answer

ADDRESS WHERE PATIENT RESIDES				
Street Address:	Apt. #:	City/Town:	State:	Zip Code:

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

PARENT INFORMATION

Relationship to Patient: : ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Foster Parent ☐ Other:

Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address:	Apt. #:	City/Town:	State:	Zip Code:
Street Address: ☐ Same as above	Apt. #:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:	Email Address (1):		
	Preferred Language:	Need interpreter? ☐ Yes ☐ No		

OTHER PARENT INFORMATION

Relationship to Patient: : ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Foster Parent ☐ Other:

Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address: ☐ Same as above	Apt.#:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:	Email Address (2):		

CONTACT METHOD			
Phone 1:	☐ Home ☐ Cell ☐ Cell Mom ☐ Cell Dad	Phone 2:	☐ Home ☐ Cell ☐ Cell Mom ☐ Cell Dad
Phone 3:	☐ Cell Mom ☐ Cell Dad ☐ Work Mom ☐ Work Dad	Phone 4:	☐ Work Mom ☐ Work Dad ☐ Other ________________

EMERGENCY CONTACT OR DHS CASE WORKER	
First and Last Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

BILLING INFORMATION

☐ Self-Pay (No Insurance)

☐ OHP: Tuality Health Alliance/ Care Oregon/ DMAP *(circle one)*

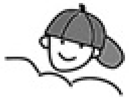
Client ID #: ____________________

☐ INSURANCE (Primary) Effective Date: ____/____/____
Insurance Name: _______________________________
Subscriber Name: _________________ DOB: ____/____/____
Policy #: _____________________________________
Group #: ________________________ Copay: $ ___________

☐ INSURANCE (Secondary) Effective Date: ____/____/____
Insurance Name: _______________________________
Subscriber Name: _________________ DOB: ____/____/____
Policy #: _____________________________________
Group #:________________________ Copay: $ ___________

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

Hillsboro Pediatric Clinic LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-640-2757.
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-640-2757.

HPC REG CONSENTS Hillsboro Pediatric Clinic LLC 

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐ Male ☐ Female	Birth Date:

THE FOLLOWING CONSENTS AND PERMISSIONS APPLY TO ME AND MY CHILD

Pharmacy: I hereby authorize Hillsboro Pediatric Clinic LLC (HPC) to electronically send prescriptions to a participating pharmacy of my choice. HPC may electronically receive information regarding my and/or my child's prescription history, drug interactions, prior authorization requirements or required substitutions.

Pharmacy Name: ______________________________ **Location:** ______________________

Contact Preferences: I would prefer that HPC use the preferred contact method indicated below when confirming appointments:

☐ Phone ☐ Email ☐ Text

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 is 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 am involved in my and/or my child's care. The goal is to ensure that my and/or my child's healthcare needs are coordinated for the best possible health outcome. For more details I recognize that I have access to a Medical Home Brochure.

Authorization to Treat: By my signature below I give permission to HPC to treat me and/or my child. By signing this form, I am consenting to the Clinic's use and disclosure of my protected health information to carry out treatment, payment or healthcare operations. 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 patient listed above.

I ATTEST TO THE ABOVE:

Patient or Legal Guardian Name: ______________________ **Relationship to patient:** ____________

Signature:__________________________________ **Date:** ______________________

Notice of Privacy Practices: I also acknowledge that I have access to a complete copy of HPC's Notice of Privacy Practices, which describes in detail how medical information about me and/or my child may be used and disclosed, and how I can get access to this information.

I ATTEST TO THE ABOVE:

Signature:__________________________________ **Date:** ______________________

☐ Patient or responsible party refused to sign the acknowledgement. ____________ ____________

Financial Responsibility and Assignment of Insurance Benefits

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

Financial Policies of Hillsboro Pediatric Clinic LLC (HPC)

1. **Co-Pays:** You must pay your co-pay at the time of service as required by your insurance company.
2. **Accepted forms of payment:** We accept cash, check, MasterCard, Visa, Discover and debit cards.
3. **Discounts:** Cash discounts will be given for patients without insurance if you pay in full for services on the day of the visit: 10% (ten percent) if paid by cash or check and 5% (five percent) if paid with a credit or debit card. If your check is returned NSF by the bank, the 10% discount will be reversed and you will be billed for the full fee.
4. **NSF Charges:** A returned check for non-sufficient funds will result in a charge of $25.00. This fee is due and payable upon receipt of our bill.
5. **Financial Hardship:** If you are going through a financial hardship and cannot pay your bill, it is your responsibility to contact our Billing Department to inquire about financial assistance offered by HPC.
6. **No Insurance/Self Pay:** If you do not have health insurance or proof of coverage, we require a $125.00 deposit before your first visit, and a $50.00 for each visit after that. These deposits will be applied to our bill for medical services; and any remaining balance will be billed to you or any overpayment will be refunded to you. If you do not have insurance, the Oregon Vaccines for Children program will cover the cost of vaccines. You will be billed for the small cost of administering the vaccine.
7. **Insurance billing:** You are responsible to know your insurance benefits, including what is and is not covered. We will bill your primary insurance company when you provide us with current and complete information. By signing below, you agree you are responsible to pay for all services that your insurance has denied and for amounts not paid under this assignment, including your health insurance deductible, coinsurance and copays.
8. **Secondary insurance billing**: As a courtesy to you, we will file a secondary claim once for each visit.
9. **Statements:** Even though an insurance claim may be pending, you may receive a statement if your account has an outstanding balance. HPC cannot accept responsibility to collect your insurance claim or to negotiate a settlement on a disputed claim.
10. **Payments on Account Balances:** You are responsible for the timely payment of your account. All unpaid amounts are due and payable within 15 (fifteen) days of the statement date and no later than 60 (sixty) days after the date of service, regardless of insurance status or disputes.
11. **Oregon Health Plan:** If we are unable to verify your coverage, you will be given the option of signing a waiver accepting responsibility of any balance accrued for that visit.
12. **Collections:** Accounts assigned to a credit reporting and collections service will be charged a $50.00 collection fee. Discounts previously allowed will be reversed and you will be billed the full fee. Should the account be referred to an attorney for collection, the undersigned shall also pay reasonable attorney's fees and collection expense.

I, as the responsible party, hereby authorize payment directly to HPC for health care benefits. This authorization is effective for any providers for whom HPC is authorized to bill in connection with its services. I understand that under this agreement I am financially responsible for all amounts due. I acknowledge and understand that bodily fluids or tissues collected by HPC will be sent to an unaffiliated lab and that I will receive a separate bill from them for tests and interpretations. I have read, fully understand and agree to the above statements.

By signing below, you agree you have read this document and agree to the statements above.
You will receive a copy of this information.

Parent or Legal Guardian Signature: ____ **Date:**_______________

Name: ____ ***Relationship to Patient***: __________________

Patient Name:____ **DOB:** __________________________________

Hillsboro Pediatric Clinic LLC
Nondiscrimination and Accessibility Notice:

Discrimination is Against the Law

Hillsboro Pediatric Clinic LLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Hillsboro Pediatric Clinic LLC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Hillsboro Pediatric Clinic LLC

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Martha Cossio, Privacy Officer.

If you believe that Hillsboro Pediatric Clinic LLC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Martha Cossio, Privacy Officer, 445 E Main St, Hillsboro, OR 97123, phone (503) 640-2757, fax (503) 640-9753, email mcossio@hillsboropediatrics.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Martha Cossio, Privacy Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-503-640-2757

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-503-640-2757.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-503-640-2757

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-503-640-2757.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-503-640-2757

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером - 1-503-640-2757

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1-503-640-2757

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-503-640-2757 (رقم

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-503-640-2757

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-503-640-2757

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-503-640-2757

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-503-640-2757

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-503-640-2757 تماس بگیرید

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-503-640-2757

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-503-640-2757

Hillsboro Pediatric Clinic LLC

PATIENT INFORMATION				
Last Name:	First:	Middle:	☐ Male ☐ Female	Birth Date:

CONSENT FOR FRIENDS AND FAMILY

In the event that I am in need of medical treatment and unable to consent for my own treatment; or my child is in need of medical treatment and I (or another legal guardian) is unable to bring in my child for treatment:

☐ I, _______________, authorize the following person(s) seek medical treatment for me or my child and to discuss protected health information (PHI) to the extent Hillsboro Pediatric Clinic, LLC deems necessary to provide care.
I understand that this might include such information as: diagnosis, prognosis and treatment plans, medication, discharge instructions and plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to the care of the patient. This authorization will remain valid until a new authorization is completed or until written notice to revoke the authorization is received.

1. ______________________________ ______________________ ______________________
Name Relationship to patient Telephone #

Additionally, the individual named above may:

☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

2. ______________________________ ______________________ ______________________
Name Relationship to patient Telephone #

Additionally, the individual named above may:

☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

3. ______________________________ ______________________ ______________________
Name Relationship to patient Telephone #

Additionally, the individual named above may:

☐ Pick-up prescriptions ☐ Pick-up documents ☐ Inquire about Referrals
☐ Make/change appointments ☐ Access insurance/billing information ☐ Inquire about test results

Name of Patient or Legal Guardian (print): ______________________________

Signature:______________________________ Date: ______________

OR

☐ I decline to authorize anyone else to seek medical treatment for me or my child.
Name of Legal Guardian (print): ______________________________

Signature:______________________________ Date: ______________

Child's Name: ______________________________ Date of Birth: ______________________

Patient History

Please answer the following questions about your baby's/child's medical and family history.
The physician may ask further details about "yes" answers.

PREGNANCY AND BIRTH:

	YES	NO
Where there any problems with pregnancy or delivery of this child?	____	____

If yes, please explain: ____

Was Baby full Term_________ or Early?__________ If early, how many weeks?______

Was your child breastfed? __________ YES __________ NO If so, for how long? __________________________

Type of Delivery: Vaginal ______ C-section ________ Length _____________ Weight ___________

Problems:

	Yes	No
Jaundice	____	____
Respiratory Distress	____	____
Feeding Problems	____	____
Rash	____	____

	Yes	No
Breech	____	____
Developmental Problems	____	____

If yes, please explain: ________________________

HOSPITALIZATIONS/OPERATIONS:

☐ NONE

Hospital	Reason	Year

MEDICATIONS AND DOSAGES (Please include over the counter, supplements, homeopathic and prescribed medications):

☐ NONE

____

____

____

ALLERGIES TO ANY MEDICATIONS? (Please list)

☐ NONE KNOWN

____

____

____

DOES YOUR CHILD SEE ANY SPECIALISTS? (Nutritionist; Occupational, Physical and/or Speech Therapist; Counselor; or other medical specialists)

☐ NONE

Name of Specialist	Reason

SOCIAL AND ENVIRONMENTAL HISTORY

	Yes	No
How many hours of exercise does your child get per day? ________		
Does your child spend more than 2 hours per day watching TV, playing video games, or on the computer?	____	____
Does anyone living in the home smoke?	____	____
Does anyone living in the home drink alcohol?	____	____
Are there smoke detectors in the home?	____	____
Seat belts used in your car?	____	____
Is your child in school or day care?	____	____
Does your child wear a bike helmet while riding?	____	____
Are there guns in your home?	____	____
Do you have the poison-control center phone number near your telephone?	____	____

Medical History (Check if your child/children have had any of the following):

Asthma	______
Anemia	______
Chicken Pox	______
Diabetes	______
Chronic diarrhea/constipation	______
Ear problems	______
Eczema (overly dry skin)	______

Epilepsy	______
Eye or vision problems	______
Kidney/Bladder problems	______
Liver disease/Jaundice	______
Tuberculosis	______
Other (Please explain)	______

____

Child's Name: ____ **Date of Birth:** ______________

Please List Patient's Biological Parents:

Mother: ____ DOB: ________

Father: ____ DOB: ________

Does Patient live with Biological Parents? (Circle one) **YES** **NO**

If No, please indicate name of person patient is living with and relationship below:

Name: ________________________________ **Relationship to Patient:** ______________________

FAMILY MEDICAL HISTORY **(Please fill out the following based only on biological family members of the patient)**

☐ CHECK HERE IF NONE OF THE CONDITIONS BELOW APPLY TO ANY BIOLOGICAL FAMILY MEMBERS

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Other
ADD/ADHD						
Allergies						
Asthma						
Birth Defects						
Cancer						
Heart Problems						
Hip Problems						
Deafness						
Depression						
Developmental Delay						
Diabetes						
Eczema						
Genetic Disorder						
Blood Disorder						
High Cholesterol						
High Blood Pressure						
Learning Disability						
Mental Retardation						
Migraines						
Obesity						
Curved Spine						
Seizure Disorder						
Sudden Infant Death						
Crossed Eyes						
Thyroid Disease						
Hepatitis						
Tuberculosis						
Other:						

________________________ ________________________ ________________________ ____________

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

+ -

Children with Special Health Care Needs Screener©

CHILD'S NAME: ______________________________ CHILD'S DATE OF BIRTH: ________________

TODAY'S DATE: ______________________ YOUR RELATIONSHIP TO PATIENT: ________________

1. Does your child currently need or use **medicine prescribed by a doctor** (other than vitamins)?
   - ❑ Yes → Go to Question 1a
   - ❑ No → Go to Question 2

   1a. Is this because of ANY medical, behavioral or other health condition?
   - ❑ Yes → Go to Question 1b
   - ❑ No → Go to Question 2

   1b. Is this a condition that has lasted or is expected to last for *at least* 12 months?
   - ❑ Yes
   - ❑ No
2. Does your child need or use more **medical care, mental health or educational services** than is usual for most children of the same age?
   - ❑ Yes → Go to Question 2a
   - ❑ No → Go to Question 3

   2a. Is this because of ANY medical, behavioral or other health condition?
   - ❑ Yes → Go to Question 2b
   - ❑ No → Go to Question 3

   2b. Is this a condition that has lasted or is expected to last for *at least* 12 months?
   - ❑ Yes
   - ❑ No
3. Is your child **limited or prevented** in any way in his or her ability to do the things most children of the same age can do?
   - ❑ Yes → Go to Question 3a
   - ❑ No → Go to Question 4

   3a. Is this because of ANY medical, behavioral or other health condition?
   - ❑ Yes → Go to Question 3b
   - ❑ No → Go to Question 4

   3b. Is this a condition that has lasted or is expected to last for *at least* 12 months?
   - ❑ Yes
   - ❑ No
4. Does your child need or get **special therapy**, such as physical, occupational or speech therapy?
   - ❑ Yes → Go to Question 4a
   - ❑ No → Go to Question 5

   4a. Is this because of ANY medical, behavioral or other health condition?
   - ❑ Yes → Go to Question 4b
   - ❑ No → Go to Question 5

   4b. Is this a condition that has lasted or is expected to last for *at least* 12 months?
   - ❑ Yes
   - ❑ No
5. Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets **treatment or counseling**?
   - ❑ Yes → Go to Question 5a
   - ❑ No

   5a. Has this problem lasted or is expected to last for *at least* 12 months?
   - ❑ Yes
   - ❑ No