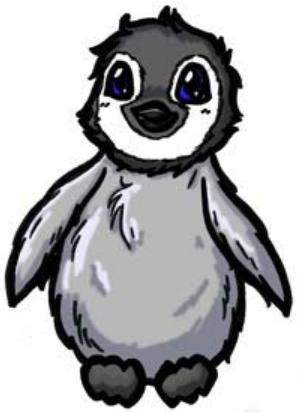
Welcome to your Medical Home!

Hillsboro Pediatric Clinic, LLC

Enclosed is our New Patient Packet.
The patient's **Legal Parent or Guardian** must complete this packet.

For the child's first appointment:

1. A legal parent/guardian must be with the child. If they are unable to bring the child, the legal parent/guardian must complete steps 2-5 prior to the appointment. Stepparents cannot consent to treatment for minor children. The legal parent/guardian must complete the Friends and Family form to allow stepparents or other individuals to consent to the child's care in their absence.
2. Complete, sign and bring all the forms in this packet.
3. The legal parent/guardian should bring their photo ID.
4. Bring the child's immunization record.
5. Bring the child's insurance card.
6. Be prepared to pay the required copay for the child's insurance.
7. Bring previous doctor records, if you have them.
8. Arrive 30 minutes before the scheduled appointment. If the forms are not complete by the scheduled appointment time, we may have to reschedule the appointment.

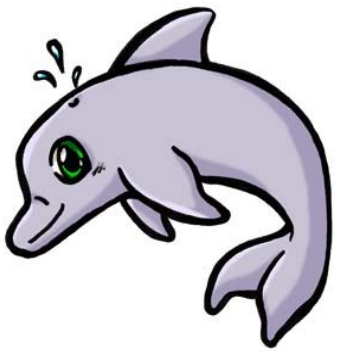


Main Street
445 E Main St
Hillsboro, OR 97123
Mon thru Thur: 8am – 8pm
Fri: 8am – 5pm
Sat: 9am – 12pm

Orenco Station
6125 NE Cornell Rd
Suite 240
Hillsboro, OR 97124
Mon thru Fri: 8am – 5pm

(503) 640-2757

HillsboroPeds.com



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

Legal Last Name:	Legal First:	Middle:	Birth Date:
Preferred Name:		Preferred Pronouns:	Sex at birth: ☐ Male ☐ Female

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

ADDRESS WHERE PATIENT LIVES

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: ☐ OHSU Health Services ☐ Care Oregon ☐ Yamhill Coordinated Care ☐ DMAP

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			
Legal Last Name:	Legal First:	Middle:	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, Behavioral Health Providers, 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. _____ _____Hillsboro

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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. This deposit 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: _____

CANCELLATION/NO SHOW POLICY Hillsboro Pediatric Clinic LLC

PATIENT INFORMATION			
Last Name:	Legal First:	Middle:	Birth Date:

Hillsboro Pediatric Clinic (HPC), its providers and staff, are committed to providing your child - and all of our patients - with exceptional care. When you chose HPC, you made us a partner in your child's healthcare. To be a productive partner, we need to carefully manage our time to make ourselves available to our patients as we are needed. In order to achieve this, we must make sure that our patients fulfill their appointment commitments.

We understand that sometimes things happen that prevent us from doing what we had planned. When a patient's plan changes and they cancel without giving us enough notice, we cannot use that appointment for another patient to be seen. We put the following policies into place for this reason.

General Cancelling/Rescheduling Guidelines:
Call us at 503-640-2757 at least 24 hours before your scheduled appointment to notify tell us of any changes or cancellations. Failure to give at least one hours' notice of rescheduling or cancelling an appointment will be considered a no show appointment.

- **Cancelled Appointment:** Call the clinic with **more than 24 hours' notice** of scheduled appointment. (*For Example: To cancel a Monday appointment, please call our office by Saturday at 11:00 am.)*
- **Late Cancellation:** Call the clinic to cancel or reschedule the appointment with **less than 24 hours' notice**. (Late cancellation will still apply even if the appointment is rescheduled for same day or next day)
- **No Show:** Not coming to a scheduled appointment or calling less than an hour before the appointment to cancel or reschedule.

Warning Letters:
First and Second warning letters will be mailed when all the children in the family have a combined total of 2 and 3 No Shows, or 3 and 4 Late Cancellation appointments.

NOTE: Evening appointments are usually reserved for sick or injury visits; however, there are times when we are able to schedule limited routine visits in the evenings. There are not enough routine evening appointments for everyone who wants one. If your child is scheduled for a routine visit in the evening and No Shows, your child(ren) may not be able to have routine visits in the evening in the future. If this happens, we will tell you. Your child(ren) will still be able to have appointments for sick or injury visits in the evening.

Termination of Care Letter:
If No show or late cancellation behavior continues after the warning letters, you may be asked to find a new primary care provider.

Please feel free to call us at any time if there are problems that make it difficult for you to keep your child's appointments. Our Care Coordinators may be able to direct you to resources that can help.

Thank you for partnering with us!

_____
Responsible Party Full Name

_____ _____
Signature of Parent/Legal Guardian Date

Hillsboro Pediatric Clinic LLC

PATIENT INFORMATION			
Legal Last Name:	Legal First:	Middle:	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		Yes	No
Jaundice	☐	☐	Breech	☐	☐
Respiratory Distress	☐	☐	Developmental Problems	☐	☐
Feeding Problems	☐	☐	If yes, please explain:		
Rash	☐	☐			

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 baby/child has had any of the following):

Asthma	☐	Epilepsy	☐
Anemia	☐	Eye or vision problems	☐
Chicken Pox	☐	Kidney/Bladder problems	☐
Diabetes	☐	Liver disease/Jaundice	☐
Chronic diarrhea/constipation	☐	Tuberculosis	☐
Ear problems	☐	Other (Please explain)	☐
Eczema (overly dry skin)	☐	_____	

Child's Name: _____ **Date of Birth:** _____

Please List Patient's Biological Parents:

Mother: _____ DOB: _____

Father: _____ DOB: _____

Does Patient live with Biological Parents? (Check 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	☐	☐	☐	☐	☐	
Intellectual Disability	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐	
Obesity	☐	☐	☐	☐	☐	
Curved Spine	☐	☐	☐	☐	☐	
Seizure Disorder	☐	☐	☐	☐	☐	
Sudden Infant Death	☐	☐	☐	☐	☐	
Crossed Eyes	☐	☐	☐	☐	☐	
Thyroid Disease	☐	☐	☐	☐	☐	
Hepatitis	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

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

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 the 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: Privacy Officer, 445 E Main St, Hillsboro, OR 97123, phone (503) 640-2757, fax (503) 640-9753, email jmerida@hillsboropediatrics.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

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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 تماس بگیرید 1-503-640-2757

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