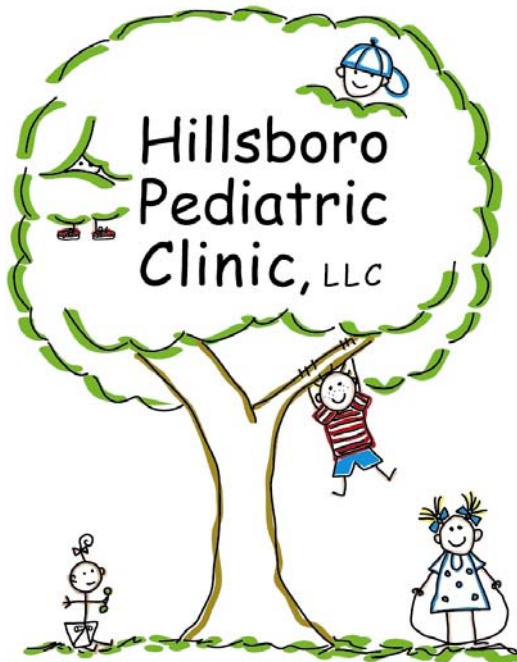


Welcome to your Medical Home!



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 **NOTE**: If Legal Guardian is checked below, we assume this person has full legal guardianship status unless otherwise stated. **Please print.**

PATIENT INFORMATION				
Legal Last Name:	Legal First:	Middle:	Birth Date:	
Preferred Name:		Pronouns:	Sex at birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White, not Hispanic <input type="checkbox"/> Hispanic				
ADDRESS WHERE PATIENT LIVES				
Street Address:	Apt. #:	City/Town:	State:	Zip Code:
Resides with: (check all that apply) <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Resource Parent <input type="checkbox"/> Other:				
CONTACT INFORMATION				
Relationship to Patient: (check all that apply) <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Resource Parent <input type="checkbox"/> DHS <input type="checkbox"/> Other:				
Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address:	Apt. #:	City/Town:	State:	Zip Code:
Street Address: <input type="checkbox"/> Same as above	Apt. #:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:		Email Address (1):	
Preferred Language:			Need interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
OTHER CONTACT INFORMATION				
Relationship to Patient: (check all that apply) <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Resource Parent <input type="checkbox"/> DHS <input type="checkbox"/> Other:				
Last Name:	First Name:	Middle:	Birthdate:	
Mailing Address: <input type="checkbox"/> Same as above	Apt. #:	City/Town:	State:	Zip Code:
Employer:	Social Security Number:		Email Address (2):	
CONTACT METHOD				
Phone 1:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Cell Mom <input type="checkbox"/> Cell Dad	Phone 2:	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Cell Mom <input type="checkbox"/> Cell Dad	
Phone 3:	<input type="checkbox"/> Cell Mom <input type="checkbox"/> Cell Dad <input type="checkbox"/> Work Mom <input type="checkbox"/> Work Dad	Phone 4:	<input type="checkbox"/> Work Mom <input type="checkbox"/> Work Dad <input type="checkbox"/> Other	
BILLING INFORMATION				
<input type="checkbox"/> Self-Pay (No Insurance)		OHP: <input type="checkbox"/> OHSU Health Services <input type="checkbox"/> Care Oregon <input type="checkbox"/> Yamhill Coordinated Care <input type="checkbox"/> DMAP		
		Client ID #: _____		
<input type="checkbox"/> INSURANCE (Primary) Effective Date: ___/___/___ Insurance Name: _____ Subscriber Name: _____ DOB: ___/___/___ Policy #: _____ Group #: _____ Copay: \$ _____		<input type="checkbox"/> INSURANCE (Secondary) Effective Date: ___/___/___ Insurance Name: _____ Subscriber Name: _____ DOB: ___/___/___ Policy #: _____ Group #: _____ Copay: \$ _____		

Signature

Print Name

Relationship to Patient

Date

--	--	--	--



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

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.

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)

- Co-Pays:** You must pay your co-pay at the time of service as required by your insurance company.
- Accepted forms of payment:** We accept cash, check, MasterCard, Visa, Discover and debit cards.
- 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.
- 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.
- 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.
- 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.
- 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.
- Secondary insurance billing:** As a courtesy to you, we will file a secondary claim once for each visit.
- 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.
- 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.
- 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.
- 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 (or self):** _____

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



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:

<input type="checkbox"/> Pick-up prescriptions	<input type="checkbox"/> Pick-up documents	<input type="checkbox"/> Inquire about Referrals
<input type="checkbox"/> Make/change appointments	<input type="checkbox"/> Access insurance/billing information	<input type="checkbox"/> Inquire about test results

2. _____
 Name Relationship to patient Telephone #

Additionally, the individual named above may:

<input type="checkbox"/> Pick-up prescriptions	<input type="checkbox"/> Pick-up documents	<input type="checkbox"/> Inquire about Referrals
<input type="checkbox"/> Make/change appointments	<input type="checkbox"/> Access insurance/billing information	<input type="checkbox"/> Inquire about test results

3. _____
 Name Relationship to patient Telephone #

Additionally, the individual named above may:

<input type="checkbox"/> Pick-up prescriptions	<input type="checkbox"/> Pick-up documents	<input type="checkbox"/> Inquire about Referrals
<input type="checkbox"/> Make/change appointments	<input type="checkbox"/> Access insurance/billing information	<input type="checkbox"/> 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? YES NO

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 | <input type="checkbox"/> | <input type="checkbox"/> | Breech | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Distress | <input type="checkbox"/> | <input type="checkbox"/> | Developmental Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | If yes, please explain: | | |
| Rash | <input type="checkbox"/> | <input type="checkbox"/> | | | |

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? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child spend more than 2 hours per day watching TV, playing video games, or on the computer? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does anyone living in the home smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does anyone living in the home drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there smoke detectors in the home? | <input type="checkbox"/> | <input type="checkbox"/> |
| Seat belts used in your car? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child in school or day care? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child wear a bike helmet while riding? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there guns in your home? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are the guns safely stored (i.e. Locked in a gun safe)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have the poison-control center phone number near your telephone? | <input type="checkbox"/> | <input type="checkbox"/> |

Medical History (Check if your baby/child has had any of the following):

- | | | | |
|-------------------------------|--------------------------|-------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | Eye or vision problems | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | Kidney/Bladder problems | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Liver disease/Jaundice | <input type="checkbox"/> |
| Chronic diarrhea/constipation | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> |
| Ear problems | <input type="checkbox"/> | Other (Please explain) | <input type="checkbox"/> |
| Eczema (overly dry skin) | <input type="checkbox"/> | | |

MORE ON BACK



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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hip Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genetic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Curved Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sudden Infant Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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, exclude or treat people differently based on race, (including traits associated with race such as hair texture/styles), religion, color, sex, sexual orientation, gender identity, national origin, mental or physical disability, pregnancy, uniformed/military service or veteran's status, or marital status.



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 against based on race, (including traits associated with race such as hair texture/styles), religion, color, sex, sexual orientation, gender identity, national origin, mental or physical disability, pregnancy, uniformed/military service or veteran's status, or marital status, you can file a grievance with: Privacy Officer, 445 E Main St, Hillsboro, OR 97123, phone (503) 640-2757, fax (503) 640-9753, email iaguilar@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>.

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 503-640-2757-1 (رقم برقم

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អល 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 بگیری 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