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			
Legal Last Name:	Legal First:	Middle:	Birth Date:
Preferred Name:		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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ 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:	Email Address:	

Preferred Language:
Need Interpreter? ☐ Yes ☐ No

Responsible Party Preferred Language:
Need Interpreter? ☐ Yes ☐ No

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

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

BILLING INFORMATION

☐ Private 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 $: _____

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**	**Date**

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

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) am 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 #

Preferred Language:_____ Need Interpreter? ☐ Yes ☐ No

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

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2. _____ _____ _____
Name | Relationship to patient | Telephone #

Preferred Language:_____ Need Interpreter? ☐ Yes ☐ No

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

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3. _____ _____ _____
Name | Relationship to patient | Telephone #

Preferred Language:_____ Need Interpreter? ☐ Yes ☐ No

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

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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: _____