PATIENT INFORMATION

HARRISON FAMILY MEDICINE

1100 Southgate Suite 2
Pendleton, Oregon 97801
541-215-1564 (phone)
541-215-1567 (fax)

☐ **Dr. Russell Harrison, M.D.** ☐ **Dr. Andrea Carrasco** ☐ **Erika Acuna, PA-C** ☐ **Linda Harries, PA-C**

Please provide your photo ID at your first visit.

Social Security #_____Date of Birth _____/_____/_____ Sex M ☐ F ☐

First Name _____Middle_____Last Name_____

Mailing Address _____City _____State_____Zip_____

Mark an X by your preferred phone ***Would you prefer a text message or phone call for reminder calls.*** _____

__Cell Phone (____) _____ __Home Phone (___)_____ __Work Phone (____)_____

Email_____ Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment Status ☐ Employed ☐ Retired ☐ Self-Employed ☐ Full-time Student ☐ Unemployed

Employer/Company Name_____

INSURANCE INFORMATION (please provide your insurance card to the receptionist**)**

Insurance Company_____ Policy #_____ Group #_____

Insured/Card Holder's Name_____ Relationship_____ Date of Birth____/____/_____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company_____ Policy #_____ Group #_____

Insured/Card Holder's Name_____ Relationship_____

Social Security #_____ Date of Birth _____/_____/_____

RESPONSIBLE PARTY (if signed on behalf of the patient) **PARENT** ☐ **GUARANTOR** ☐ **OTHER** ☐

First Name _____Middle_____Last Name_____

Mailing Address _____City _____State_____Zip_____

Home Phone (____) _____ Cell Phone (_____)_____ Work Phone (____)_____

PHARMACY INFORMATION

☐ Pendleton Bi-Mart ☐ Pendleton Safeway ☐ Yellow hawk Pharmacy
☐ Pendleton Rite-Aid ☐ Pendleton Wal-Mart ☐ Pendleton Walgreens
Other:_____

EMERGENCY CONTACT

First name_____ Last Name_____ Relationship_____ Sex M ☐ F ☐

Home Phone (____) _____ Cell Phone (_____)_____ Work Phone (____)_____

X_____ X_____

Patient Signature (or Parent if Minor) **Date**

TODAY'S DATE: X _____ **Harrison Family Medicine**

NAME: *(Last, First, MI)* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY		
List any medical problems that other doctors have diagnosed		
-	-	
-	-	
-	-	
-	-	
Surgeries and Hospitalizations		
Year	Reason	Hospital
Last Colonoscopy: _____ Last Mammogram: _____ Last Pap: _____		
Other providers you see:		
Name:		Specialty:
Other:		
Education: (Highest level and degree)		
Work:		
Primary language:		
Living Situation:	☐ Private Residence ☐ Assisted Living ☐ Nursing Home	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Medication Name	Reaction You Had	

Name:_____

FAMILY HEALTH HISTORY					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

HEALTH HABITS AND PERSONAL SAFETY					
Exercise	Do you exercise?			☐ Yes	☐ No
	If yes: _____ min of _____ (type) _____(#) days per week				
Diet	☐ Normal ☐ Vegetarian ☐ Vegan ☐ Low Fat ☐ Low Carb ☐ Frequent fast/fried/pre-packaged food				
	Other:				
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes- packs/day _____ ☐ Chew- #/day_____ ☐ Pipe- #/day_____ ☐ Cigars- #/day_____				
	☐ # of years _____ ☐ Or year quit _____				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
Drugs	Do you currently use recreational or street drugs (includes marijuana)?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy, list contraceptive or barrier method used:				
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?			☐ Yes	☐ No
Females only:	Number of pregnancies: _____ Number of live births: _____				
	OR: Age at onset of menopause: _____				

HARRISON FAMILY MEDICINE

Dr. Russell Harrison
Dr. Andrea Carrasco
Erika Acuna, PA-C
Linda Harries, PA-C

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others except those involved in your continued care unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get any information about it by contacting our medical records person. A fee may apply.

Please list any individuals (family members, etc.) to whom you give us permission to discuss and/or release your medical records to:

_____ _____

Authorized individual Authorized individual

In order to insure your privacy, you will be asked to provide your photo ID which will be copied and retained within your chart for identification purposes.

Before our office will release your information we will take reasonable precautions to ensure they are indeed one of the people or part of an entity which you have listed above and/or are involved with your direct medical care. Your information is automatically released to offices, hospitals, labs, etc. for the purpose of treatment, payment or health care operations, per the HIPAA Privacy Act.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information is available for you in our waiting room.

By my signature below I acknowledge I was given the opportunity to receive the Notice of Privacy Practices and I wish for my information to be released to those individuals or entities and indicated above.

X_____ X_____

Patient signature (or legally-authorized individual) Date

_____ _____

Printed name (if signed on behalf of the patient) Relationship

HARRISON FAMILY MEDICINE

CREDITS & DISCLAIMER POLICY

***CASH – FIRST OFFICE VISIT IN FULL OR A $85.00 MINIMUM DEPOSIT.**
Please note that your balance may be more than the minimum. Actual amount of visit may be determined after you have seen the physician.

If paying cash please sign that you have read and understand the above statement:

Sign: _____ Date: _____

***Co-Payment –** Your co-payment is due at the time of service.
Note: Your co-payment is your obligation.
It is part of your contracted policy between you and your insurance.
***Insurance** – We are preferred providers with several carriers
***Debit Cards** – All banks
***Credit cards** – Visa and MasterCard

Patient Billing Statement:

- **Responsibility for payment of your account remains with you at all times;** and although you may have a pending insurance claim, we must look to you for payment regardless of the circumstances involved. Please contact us immediately if there is a problem with your claim or if it is related to OREGON WORKERS COMP, AUTO RELATED OR THE RESPONSIBILITY OF A THIRD PARTY PAYOR.

- You will receive a monthly statement showing itemized charges and the total due on your account. Payment in full is required in 30 days unless arrangements are made with our billing office.

- If you are not insured our billing department will be happy to arrange a reasonable payment plan with you.

- A $30.00 no show charge may be assessed after two missed appointments within 1 year. Three no shows within a one year time frame may result in you being discharged from the practice.

- There will be a $25.00 fee charged for all returned checks.

- NO CREDIT will be extended to patients having a delinquent account or who have been referred to a collection agency. If your account has to be referred to a collection agency two times you will be discharged from this practice.

*Signature needed on next page

INSURANCE BILLING:

NON-CONTRACTED PLANS: We handle billing for all contracted plans. As a courtesy to our patients with non-contracted plans we will bill your claim for you provided we have a current copy of your insurance card in your file at all times.

PREFERRED PROVIDER PLANS: With certain insurance companies, it is necessary for you to be treated by a preferred provider to ensure complete coverage. If your doctors are not on the preferred panel, you will be responsible for "non network provider" charges. Please call your insurance to verify that your insurance is preferred with our office.

OREGON WORKERS COMPENSATION: It is your responsibility to advise the receptionist PRIOR to your appointment that it is a work related injury! A separate workers comp form will be required. If the claim is DENIED or CLOSED or if you fail to inform us of the work related nature, including appropriate claim information, you will be responsible for all charges.

AUTO RELATED INJURY: All relevant auto insurance information must be on file in order for us to bill your auto insurance including date of injury, policy number and claim number (if applicable). Oregon is a no fault state meaning that we will bill YOUR insurance regardless of who's fault the accident is.

MEDICARE: Supplemental insurance processing will be provided when the required insurance information is presented at registration. Medicare considers some procedures and lab work as "not medically necessary". In this case you will be instructed of your rights and offered an ABN (Advanced beneficiary Notice) which will put any charges not covered by Medicare in your responsibility. If you do not wish to sign an ABN you may be asked to cancel your procedure. **Medicare requires that we have a current copy of your Medicare card on file!**

EOCCO: WE REQUIRE A CURRENT COPY OF YOUR CARD AT EACH VISIT. This allows us to determine which physician you are assigned to. If we cannot determine eligibility, cash will be required at the time of service.

OHP (OPEN CARD) WE DO NOT ACCEPT THE OPEN CARD UNLESS IT IS SECONDARY TO MEDICARE!!!!

SECONDARY INSURANCE: We will bill your secondary insurance providing we have current copies of your card and all information necessary to bill the claim. If the information is not available you will be responsible for any balances not paid by your primary insurance.

ASSIGNMENT OF BENEFITS:

I/We hereby agree to have insurance benefits sent directly to HARRISON FAMILY MEDICINE. I/WE understand that I/we are responsible for those charges not paid by the insurance company as noted in the terms in this agreement. I/we are additionally responsible for follow up billing of my insurance company unless otherwise instructed by this clinic. I/We hereby authorize the release of essential information to such insurance companies to establish my claim. I/We understand my insurance will not be billed without a current copy of my insurance card on file.

I/We understand and agree to the Harrison Family Medicine financial policy.

X_____ **X** _____

Signature **Date**

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

******IF MORE THAN 25 PAGES PLEASE MAIL RECORDS******

_____ _____

(Name of Patient) (Date of Birth)

I hereby authorize the release of medical information regarding the patient named above by copy of medical records and/or by discussing the information in person or by phone.

Consisting of: Chart Notes_____ Labs/pathology_____ Imaging _____

Date of range of Information needed: Current Records _____ last 5 years_____
All Records_____

Purpose of Need for this Information: Continuing care_____ Copies for own use_____
Other_____

From: _____

Address_____

City, State, Zip Code _____

(Phone) _____ (Fax) _____

TO: HARRISON FAMILY MEDICINE

1100 Southgate Suite 2
Pendleton, Oregon 97801
(phone) 541-215-1564
(fax) 541-215-1567

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____HIV/AIDS information_____Mental health information_____Genetic testing information

_____Alcohol/Chemical Dependency diagnosis, treatment, or referral information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require my authorization prior to redisclosure.

PATIENT INFORMATION You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services if the health care services represent research related treatment and the authorization is necessary to participate in the research study and received research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Melanie Contor at 1100 Southgate Ave Pendleton, Oregon 97801 and state you are revoking this authorization.

Unless revoked, this authorization expires in one (1) year from the date of signing and shall remain in effect for the period reasonably needed to complete the requirement.

By: _____ Date: _____