Date: ___/___/_____

BENSON Health Clinic

PATIENT INFORMATION ***(Please Print)***

Last Name | First | MI | Marital Status ☐ M ☐ S ☐ D ☐ W

Street Address | City | State | Zip Code

Mailing Address (if different) | City | State | Zip Code

Home Phone | Cell Phone | Gender ☐ M ☐ F ☐ T | Birth Date | Age

Primary Care Physician | Referred by: ☐ Primary Care Physician ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Newspaper ☐ Other ☐ Website

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible for Bill | Address | Phone Number ( )

Employer | Work Number ( )

PRIMARY INSURANCE INFORMATION

Insurance Company | Employer | ID/Policy Number | Group Number | Effective Date

Address of Insured Party | City | State | Zip Code | Phone Number ( )

Named of Insured Party | Birthdate | Relationship to Patient

SECONDARY INSURANCE INFORMATION

Insurance Company | Employer | ID/Policy Number | Group Number | Effective Date

Address | City | State | Zip Code | Phone Number ( )

Named of Insured Party | Birth Date | Relationship to Patient

PERSON TO CONTACT IN CASE OF EMERGENCY

Name | Relationship to Patient | Phone Number ( )

In order to comply with the new Health Care Mandates, Benson Health Clinic is *required* to collect the following information.

Race: □White □ Asian □ Black/African Amer. □ Native Hawaiian/Pacific Islander □ American Indian/Alaskan Native □ Declined

Ethnicity: □ Non-Hispanic or Latin □ Hispanic □ Declined

Preferred Language: □ English □ Spanish □ Indian (Includes Hindi & Tamil) □ Korean □ Other:_____

BENSON Health Clinic

Patient Financial Agreement

- Benson Health Clinic participates with Medicare, Medicaid and Commercial Insurances. While Benson Health Clinic may have an agreement with your insurance, it is your responsibility to know if your plan is in network. Benson Health Clinic makes every effort to verify your insurance eligibility, deductible amounts, and co-insurance amounts prior to your initial visit. However, we cannot guarantee the amount stated, as the benefits quoted to us by your insurance are not a guarantee of payment. Many insurance companies have additional stipulations that may affect your coverage. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered necessary under your medical insurance company. By contract, covered charges will be paid directly to Benson Health Clinic. Any applicable co-payment, co-insurance payment and/or deductible are due at the time of service.
- You will be billed for any amounts due, and it is your financial responsibility to pay these amounts prior to your next appointment. You will be responsible for any collection, interest, or legal expenses associated with the collection efforts. A returned check fee of $35 may be assessed for non-sufficient funds. If something has happened and you need extra time to pay, please call, as we would like to work with you. However, we cannot unless you contact us.
- By signing below, I agree that if I cannot make it to a scheduled appointment, I must call and cancel the appointment 24 to 48 hours in advance. I understand I am responsible for paying for any missed appointments or appointments which are cancelled less than 24 hours in advance. I understand that if I do not follow this agreement, Benson Health Clinic reserves the right to deny services. I understand that failing to attend, or late cancellation of, three scheduled appointments may result in being dismissed as a client. Oregon Health Plan clients will not be billed for missed appointments, but are still required to follow the 24 to 48-hour cancellation policy.
- During your appointment, your provider may order additional medical services, such as laboratory test, which will need to be sent out of the clinic to be processed. In this case you may receive a separate bill from an external company, which will be your responsibility.
- <u>If you make an appointment for a wellness visit/physical only and your provider treats you for an illness or counsels you regarding a medical condition during the visit, a separate co-pay or deductible may be your responsibility.</u>
- Patients who opt to accept treatment services without insurance coverage are required to pay for the services upfront or at the time of service. If your account is delinquent, you will need to bring your account current prior to seeing your provider.

I understand this it is my responsibility to know what the terms of my insurance are, and in compliance with those terms, agree to the following:

- I will pay all applicable co-pays and outstanding balances as they become due.
- I assign medical benefits paid by my insurance carrier(s) to Benson Health Clinic, for application to my account. I acknowledge that I will be billed for charges not covered under my insurance policy.
- I hereby authorize Benson Health Clinic to provide the insurance company, payers or their representatives, any and all information required to process my claims, which may include treatment/testing for HIV related conditions or Mental Health counseling or treatment information.
- By signing below, I acknowledge that I have read and chosen to accept the terms outlined above, and agree to proceed with treatment at Benson Health Clinic. I understand that my refusal to not sign this form will be interpreted as my decision to discontinue care with Benson Health Clinic. <u>Practice Policy and HIPAA rights available at front desk.</u>

_____

Patient Signature (or legal guardian/representative) Date

Please print patient name or responsible party (if different than patient) Date

BENSON Health Clinic
66 Club Rd. Suite 140/160 Eugene, OR 97401
PO Box 70779 Springfield, OR 97475
Ph: (541)345-1722 Fax:(541)485-7049

PRACTICE POLICY- PATIENT INFORMATION

Our office is open Monday through Thursday 8am – 5pm with lunch from 12-1pm and Friday 8am – 12pm. We are closed on most national holidays and for severe weather conditions we follow Eugene 4j school district for closures or delays. Phones are forwarded to our answering service from 12:00 to 1:00 pm, after hours and on weekends. Your call may also be answered by voicemail if we are unable to answer during business hours. We will return your call by the next business day.

First Appointment

- Please arrive 30 minutes early to complete all registration paperwork, including insurance and/or billing information.
- Sign release forms to allow other providers or caregivers to exchange information about treatment as needed for optimal healthcare treatment. Releases are voluntary, and may be revoked at anytime.
- Bring a copy of your current insurance card(s), driver's license or other photo identification, and a list of current medications.

Expectations of Patient /Provider Relationship

- **Rights and Responsibilities*:*** The provider's responsibility is to bring the understanding, knowledge, skills, and experience to help you reach your treatment goals. The client's responsibility is to make choices and changes that will help you to achieve your goals. Clients have a right to participate in their treatment planning and ask about techniques and procedures at any time. Treatment is voluntary and clients have a right to decline or terminate treatment at any time. Clients have the right to access their clinical files. Clients may also request an amendment to their treatment files if they believe there may be an error. Providers have the right to terminate treatment if the client doesn't follow up with regularly scheduled appointments, prescription directions, or without cause.
- **Mutual Providers within Benson Health Clinic:** If you see more than one provider within Benson Health Clinic, you will have a shared medical chart with those providers to ensure the best continuity of care. This includes Behavioral Health, Physical Therapy and Gynecology.
- **Potential Benefits and Risks:** In the process of treatment, unpleasant or painful events may be recalled and you may temporarily feel increased anxiety and/or emotional distress. As a result of treatment, you may also find you are better able to cope, feel a reduction in stress, and develop a greater understanding of yourself and your situation. You are encouraged to talk this over with your provider.
- **Regarding Minors*:*** If you are an unemancipated minor under Oregon law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting in loco parentis ("in place of the parent"), in accordance with our legal and ethical responsibilities. Minors 14 years and older may independently consent for outpatient mental health treatment. For additional information see "Minor Rights: Access and Consent to Health Care "by the Oregon Department of Health at https://www.oregon.gov/oha/Transformation-Center/Resources/OHA-MinorConsent.pdf
- **Emergency/After Hours Information:** If you call with an emergency during business hours, your provider will be available to talk or meet with you as soon as their schedule allows. Lunch Hour (12:00-1:00pm), after hours and on weekends you will be forwarded to our voice messaging system. Our Voicemail is not for psychiatric or medical emergencies. If you are unable to reach us and cannot wait for us to return your call, please contact your primary care provider, go to the nearest emergency room, or dial 911. You may also call White Bird Crisis Line at (541) 687-4000 for an adult mental health crisis or the Crisis Response Program at (888) 989-9990 for a crisis involving a child. Both hotlines are answered 24 hours a day, seven days per week. If your provider will be unavailable for an extended period, another provider in the office will take your call.

- **Appointments:** It is your responsibility to attend appointments as scheduled. If you do not show for three scheduled appointments, or you cancel three scheduled appointments less than 24 hours in advance in a one-year period (except in verifiable emergencies), you may be dismissed as a client. A $100.00 fee will be billed for missed appointments. OHP/Trillium clients cannot be billed for missed appointments, but are still required to follow the 24-hour cancellation policy. Please note that "24-hour notice" means calling by 9 am Tuesday to cancel an appointment for 9 am Wednesday. This will allow us time to give your appointment to someone else. Please understand that work conflicts, childcare issues, double booking appointments, or forgetting your appointment are not emergencies & you will be held responsible for the scheduled missed appointment fee. Your insurance will not pay for any portion of a missed appointment & you will be responsible for the full fee.
- **Behavioral Health Appointments*:*** Patients are to be seen, at least every 3 months or more frequently as recommended by your provider to ensure quality care and prevent clinical decompensation. Additionally, if you are assigned to a new provider and you do not show to the initial visit your chart will be closed and you will not be eligible to reschedule with our providers.
- ***Medication Refills:***
- **We require all prescription refill requests to be called into your pharmacy 3 business days prior to you needing the refill, even if the bottle states "NO REFILLS"**
- **"Hard Copy" Requests**: If the medication requires a "Hard Copy" this request must be called into Benson Health Clinic 3 business days prior to needing the refill. Any "Hard Copy" request phoned in after 3pm on a Thursday will not be processed until the following Tuesday. There is a $25.00 fee for a "Hard Copy" requested outside of regular scheduled appointment. This fee is not applicable to OHP/Trillium members and not billable to insurance companies.
- **Communication:** Any communication with the office requiring a Provider's expertise outside of a scheduled appointment (ie Phone Calls, Emails, etc) may result in a Service Fee of $25.00 if the situation is non-emergent.
- **Grievance Procedure:** You have the right to file a grievance if you feel you have not received adequate treatment or have been treated in an inappropriate manner. All grievances must be in writing within 90 days of the incident. Please address all complaints/grievances to: Amber Benson, PMHNP at PO Box 70779 Springfield, OR 97475.
  If you feel that the grievance remains unresolved you may then request addresses of agencies to forward your grievance. You will not be penalized for filing a grievance.

Extra Fees for Provider/Office Services:
(These fees are not billable to your insurance policy, so please be aware of services that may be associated with a fee)

- Missed/ Late cancel appointment - $100.00 (Less than 24hr notice- see policy above)
- Medication refills (outside of scheduled appt.) requiring a "hard copy" - $25.00 ("Hard Copy"/Schedule II)
- Nonpayment of co-payment - $5.00
- There is a $5 fee for late payments 90 days past due
- Personal Copies of Chart/Lab - .50 cents/page
- Completion of Professional forms and letters: - $25.00

PRIVACY PRACTICES

Notice of Privacy Practices: The Notice of Privacy Practices describes how and when my health information may be used and shared, as well as how I may obtain access to my health information. I understand that my provider keeps a medical record to document our treatment visits, and this information will be kept confidential unless I have signed a release of information to a third party. Additionally, your provider is required by law to release information when he/she believes immediate harm or danger to yourself or another person may occur.

- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the bottom left side of this page indicates the date of the most current NOTICE is in effect.
- You have the right to receive a copy of our most current notice in effect. If you have not yet reviewed a copy of our current NOTICE, please ask the front desk to provide you with a copy.

Benson Health Clinic
Health History/Review of Systems

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Occupation: _____

PCP: _____ Other Providers I see: _____

General Health (circle): Excellent Good Fair Poor

Reason for Seeking Medical Attention: _____

Review of Systems: **check** any of the following symptoms you have experienced in the **past year.**

Constitutional	Cardiovascular	Reproductive	Neurological	Musculoskeletal
o Chills o Fever o Weight Gain o Weight Loss	o Chest Pain o Poor Circulation o Swelling legs o Palpitations o Irregular heart rhythm o Other _____	o Painful Periods o Painful Sex o Vaginal discharge o Breast discharge o Breast lump	o Dizziness o Leg/arm numbness o Leg/arm weakness o Problems with walking o Headache o Memory loss o Seizures o Tremors o Other	o Back pain o Joint pain o Joint swelling o Muscle weakness o Neck pain o Other _____
HEENT	**Gastrointestinal**	**Integumentary** (skin, hair, nails)	**Psychiatric**	**Hematologic/ Lymphatic**
o Hearing loss o Pain in the head o Nasal drainage o Visual changes o Allergy symptoms o Head cold	o Stomach pain o Blood in stool o Change in stool o Constipation o Diarrhea o Heartburn o Change of appetite o Nausea o Vomiting o Other _____	o Hair loss o Abnormal hair growth o Hives o Itchiness o Rash o Skin lesion o Other _____	o Anxiety o Depression o Trouble sleeping o Other _____	o Easy bleeding o Easy bruising o Swollen lymph nodes o Other _____
Respiratory	**Genitourinary**	**Metabolic/ Endocrine**	**Immunologic**	**Other**
o Cough o Shortness of breath o Wheezing o Other _____	o Burning with urination o Blood in urine o Lots of urine o Frequent urination o Urinary incontinence o Urinary retention	o Cold intolerance o Heat intolerance o Always thirsty o Always hungry o Other _____	o Contact allergy o Environmental allergy o Food allergy o Seasonal allergy o Frequently getting sick o Other _____	o Traveled outside USA? o Seen a Specialist MD? o Had any hospitalizations, surgery or been to Urgent Care?

_____Reviewed with patient on _____.

Benson Health Clinic
Health History/Review of Systems

Patient Name: _____ Date: _____

Personal History (please circle and date those **YOU** have had)

	Date:		Date:
AIDS/HIV Positive:		Hernia	
Anemia		High Blood Pressure	
Angina/Heart Pain		Kidney Disease or Stones	
Arthritis or Rheumatism		Liver Disease	
Asthma or Hay Fever		Lung Disease	
Bladder or Prostate Trouble		Mental Illness	
Blood Transfusion		Migraine Headache	
Bone Disease		Paralysis	
Cancer:		Pneumonia	
Cholesterol/Triglyceride Problem		Polio	
Chronic Bronchitis		Polyps, Colon	
Colitis or Bowel Disease		Phlebitis (Clot)	
Diabetes		Scarlett Fever	
Eating Disorder		Seizures/Convulsions	
Emotional Disorder		Skin Trouble/Disease	
Eye Disease or Glaucoma		Stroke	
Gall Bladder Disease		Thyroid Disease	
Gout		Tonsils Removed (Age)	
Heart Disease		Tuberculosis	
Head Injury		Ulcers	
Hepatitis:		Urinary Tract Infection	
Other:			

Measles: _____ Mumps: _____ Rubella: _____

Chicken Pox: _____ Rheumatic Fever: _____

Other: _____

Preventative Care/Immunizations History (please date those you have had with the most current)

Diphtheria/Pertussis Tetanus: _____ Flu: _____ Pneumonia: _____

Gardasil Vaccine (HPV): _____ Shingles: _____ Meningitis: _____

Colonoscopy: _____ Pap: _____ Bone Density: _____ Mammogram: _____

Female Health History

Age of 1st period: _____ 1st day of last period: _____ Age periods stopped: _____

Currently pregnant: Y / N # of pregnancies: _____ # of live births: _____

Method of Birth Control: _____ Have you ever had an STD? _____

Have you ever had an abnormal pap: Y / N Date: _____ # of sex partners in past year? ____

Do you have history of: Endometriosis Ovarian Growths Fibroids DES exposure Infertility

Decrease or increase in sexual desire? Y / N Sexual Orientation: G L B T Q Hetero

_____Reviewed with patient on _____.

Benson Health Clinic
Health History/Review of Systems

Patient Name: _____ Date: _____

Medicines: (include Non-Prescription Drugs, Herbs and Vitamins)

Current Medication	Size/Dose	How you take

Allergies (medicine/food/etc.)	**What was your reaction?**

Social: Have you participated in the following?

Alcohol	No	Yes	How Often/Much:	
Tobacco	No	Yes	How many per day:	Quit Date:
Illicit Drugs	No	Yes	How Often:	Quit Date:
Caffeine	No	Yes	How Often/Much:	
Energy Drinks	No	Yes	How Often:	
Regular Exercise	No	Yes	Minutes:	How many times per week:
Weight:	Current:		1 year ago:	5 years ago:

Are there any cultural or personal beliefs that you would like me to know about?

_____

Are you currently or have you ever been in a relationship where you were hurt, threatened or made to feel afraid? Yes / No

Who do you live with? _____ House / Apartment / Other: _____

List any previous Hospitalizations, Chronic Illness, Surgeries, Injuries or Accidents

(List cause or type, include Psychiatric but omit pregnancies)	**Year**

_____Reviewed with patient on _____.

Benson Health Clinic
Health History/Review of Systems

Patient Name: _____ Date: _____

Family History	Age	Health	Age @ Death	Cause	Has any blood relative ever had: (if yes, indicate relation and age of onset)	
Father					Allergy/Asthma	
Mother					Arthritis/Gout	
Siblings: (m/f)					Bleeding Disorder	
1					Clotting Disorder	
2					Cancer	
3					Colon Polyp	
4					Depression	
5					Diabetes	
					Epilepsy/Seizures	
Spouse					Glaucoma	
Children: (m/f)					Heart Disease	
1					Coronary Artery Disease	
2					High Blood Pressure	
3					Liver Disease	
4					Kidney Disease	
5					Mental Illness	
					Alcohol/Substance Abuse	
					Migraines	
					Overweight	
					High Cholesterol	
					Stroke	
					Thyroid Disease	
					Osteoporosis	
					Endometriosis	
					Hysterectomy	
					Ovarian Cysts	

Prevention/Wellness

Would you like help with:

Weight Loss? Yes / No

Stopping Tobacco Use? Yes / No

An Exercise Program? Yes / No

Immunizations? Yes / No

Food and/or housing? Yes / No

Other: _____

_____Reviewed with patient on _____.