Today's Date:______________

BENSON Health Clinic

PATIENT INFORMATION *(Please Print)*

Last Name	First	MI	Date of Birth	Age
Street Address	City	State	Zip Code	
Mailing Address (if different)	City	State	Zip Code	

Primary Phone #

Sex: □ M □ F

Gender Identity: □Male □Female □Gender queer □ TransMale □ TransFemale □ Other, Specify

Marital Status: □M □S □O

Primary Care Physician (Name and Location)

Counselor/ Therapist :(if any)

ADDITIONAL INFORMATION

Name of Responsible Party/Legal Guardian	Address	Phone Number ( )
Emergency Contact:	Relationship to Patient:	Phone 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	

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

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

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

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

I certify the above information to be true and complete to the best of my knowledge:

____

Signature of Patient or Guardian Date:

BENSON Health Clinic

Informed Consent for Services and 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/Trillium clients will not be billed for missed appointments, but are still required to follow the 24 to 48-hour cancellation/appointment 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.
- 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 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 for payment, which will include diagnosis and may include treatment/testing for HIV related conditions or Mental Health counseling or treatment information.
- By signing below, I give consent and 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. This consent will remain in effect until revoked by me in writing. <u>Practice Policy and HIPAA rights available at front desk.</u>

____

Patient Signature (or legal guardian/representative) Date

____

Printed Name

A photo copy of this agreement is considered as valid as the original

BENSON Health Clinic
66 Club Rd. Suite 140 Eugene, OR 97401
PO Box 70779 Springfield, OR 97475
Tel: (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, closed on Fridays. 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.

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.

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.

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/ late cancelations. 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 10am Wednesday to cancel an appointment for 10am Thursday. 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 and you will be held responsible for the scheduled missed appointment fee. Your insurance will not pay for any portion of a missed appointment/late cancel fee and you will be responsible for the full fee.

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.

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.

Regarding Minors*:* If you are an un-emancipated 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

Communication: You may be charged for services such as phone calls, reports, completion of forms or letters, and consultations with other professionals. Your insurance will be billed for covered services; however you are expected to pay for any fees not covered by your insurance company.

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 refill(outside of scheduled appt.) requiring a "hard copy" - $25.00 ("Hard Copy"/Schedule II)
- Nonpayment of co-payment and/or balance - $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 your health information may be used and shared, as well as how you may obtain access to your health information. Understand that your provider keeps a medical record to document your treatment visits, and this information will be kept confidential unless you 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.

•66 Club Road Ste 140• Eugene OR 97401• 541-345-1722• 541-485-7049•
• Bensonhealthclinic.com•

Informed Consent for Telemedicine Services

PATIENT NAME: ___________________________________ DATE OF BIRTH: ______________
PROVIDER NAME: __________________________________ DATE CONSENT DISCUSSED: ____________

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

· Patient medical records

· Medical images

· Live two-way audio and video

· Output data from medical devices and sound and video files Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

· Improved access to medical care by enabling a patient to remain in his/her behavioral health office while the provider obtains test results and consults from healthcare practitioners at distant/other sites.

· More efficient medical evaluation and management.

· Obtaining expertise of your provider when they aren’t in the clinic.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

· In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);

· Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;

· In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;

· In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: __________

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time- such as transferring to another provider at Benson Health Clinic or transferring to another provider in my community.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my Provider of other care that I may have with other healthcare providers, whether they are electronic interactions or in person, so my provider can help me the best way they can and communicate if necessary with my other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize ________________________________ (name of Provider) to use telemedicine in the course of my diagnosis and treatment.
Signature of Patient (or person authorized to sign for patient):___________________________________
Date:________________
If authorized signer, relationship to patient: __________________
Witness: _________________________________Date:_______________

I have been offered a copy of this consent form (patient's initials) _______

Please initial after reading this page: __________

BENSON HEALTH CLINIC
66 Club Rd. Suite # 160 Eugene, OR 97401
PO BOX 70779
Springfield, OR 97475
Ph: 541-345-1722 Fax: 541-485-7049

Family/Friend Release of Information

I ____________________________________ ___________________________
(Print patient full name) (date of BIRTH)

Hereby authorize the providers and staff of Benson Health Clinic to inform and/or involve the following family members or friends of my care, treatment plan, appointments, or account status. I understand that this release will also allow the person(s) I have listed below to share information with the providers or staff regarding my condition.

____ __________________________
Name Relationship Phone number

____ __________________________
Name Relationship Phone Number

____ __________________________
Name Relationship Phone Number

____ __________________________
Name Relationship Phone Number

This authorization will remain in effect for the duration of my treatment or until revoked in writing by the patient.

By signing below I understand that the information specific to Drug and alcohol treatment, psychiatric treatment, AIDS/HIV, and genetic test information can be released with this consent.

I understand information discussed may be re-disclosed by the receiving person and may no longer be covered under federal privacy laws.

Patient Signature Date

Authorized Representative Signature Date

BENSON HEALTH CLINIC AUTHORIZATION
TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

66 Club Rd #160 Eugene, OR 97401 Tel: 541-345-1722 Fax: 541-485-7049

Mailing Address: PO Box 70779 Springfield, OR 97475

Release PHI to: ____

OR Obtain PHI from: ____

Address: ____

Phone: ______________________ **Fax:** ______________________

Patient Name: ______________________ **DOB:** ______________________

Consisting of:

☐ **Progress/Chart Notes ** last 4**** ☐ **Diagnostic Evaluations** ☐ **Medication List** ☐ **Lab Reports/Genesight Testing**

☐ **Psychological testing** ☐ **Hospital Records** ☐ **Emergency Department and Urgent Care Records**

☐**Complete medical record–Dates:**____________________

☐ **This authorization is limited to the following treatment:** ______________________________

☐ **This authorization is limited to the following time period:**______________________________

For the purpose of: ☐ **Transfer of Care** ☐ **Coordination of Care/Communication purposes** **OR**

☐ **other:** ______________________________

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 information**
____ **Drug/alcohol 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.

PROVIDER 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 is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

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 Benson Health Clinic, PO Box 70779 Springfield, OR 97475 and state that you are revoking this authorization

I have read this authorization and understand it.

______________________________ ______________________ ______________________

Signature of Patient or Authorized Representative **Relationship** **Date**
Authorized Representative MUST provide legal documentation unless patient is a minor.

This release is valid for 1 year OR until this date: __________________ (valid for a minimum of 30 days to allow for processing).