West Salem Family Practice Associates, LLC

Scott D. Bean MD | Amanda Mehlhoff FNP | Mark J. Scherlie DO Heidi S. Thomas MD | Paul G. Weaver DO | Eugene Y. Yamaguchi MD

Welcome to our practice,

We are pleased that you have chosen us to be your primary care facility. We would like to take this opportunity to familiarize you with our policies.

Please read and complete all of the enclosed paperwork and return it when you have your first appointment. Please remember to also bring your current insurance card, any copay your insurance requires and photo identification. *Copays are non-negotiable as they are required by your insurance company and will be collected at check in for each visit.

You can find details about how and when to cancel your appointments and any policies and fees associated with those in this packet. For any further questions call (503)371-3232.

We look forward to serving you,

West Salem Family Practice Staff

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Missed/Late Appointment Policy

Please give at least 24 hours of notice:

It is a policy of this office to require 1 business days' notice for all appointment cancellations to allow the maximum availability for all of our patients. Courtesy calls are attempted 24 hours prior to your appointment, however, please do not rely on these calls as they are a courtesy. To cancel your appointment please call (503)371-3232, this line is available to you 24 hours a day.

Missed/Late Appointments:

If you are 10 minutes late for your appointment, it will be treated as a missed appointment and you will be rescheduled. A bill will be sent to the patient for the missed appointment by our office. The charges for missed appointments and appointments that are canceled less than 24 hours in advance are as follows:

- Standard office visits may be charged at $25.00.
- Missed appointment fees for Physicals, Well Child Exams, Procedures, Multiple missed appointments and any other lengthy (30 minutes or more) appointment may be charged at $50.00, as considerable time is set aside for these visits.
- New patients who miss their scheduled appointment may not be permitted to schedule future appointments or be accepted into the practice by any other physician. Patients may also be dismissed from the practice due to excessive tardiness and missed appointments. *Per your physician's discretion.
- These charges are up to your physician's discretion, meaning, they could choose not to charge you, or may choose to charge the full cost of the visit. These charges are not covered by insurance and they are the patient's responsibility. The missed appointment fee must be paid prior to future office visits.

Past Medical History and Social History

Name: _____ Date: _____
Occupation: _____

Thank you for taking the time to complete and update your past medical history and personal history. This information is used solely by your doctor in evaluating your health concerns. This is privileged information and is protected by law. Be as accurate as you can. Please give approximate dates in month/year.

Surgeries/ Hospitalizations: Dates:

_____
_____
_____

Surgeries/ Hospitalizations: Dates:

_____
_____
_____

Childbirth: Pregnancies _____ Miscarriages _____ Abortions _____ Births _____

Family History: Provide information for your natural relatives only. Unnecessary if you're over 75

	Father	Mother	Gparents	Sibs	Children
Allergy/Asthma					
Alcohol abuse					
Arthritis/Gout					
Bleeding Disorder					
Colon Cancer					
Breast Cancer					
Prostate Cancer					
Glaucoma					
Heart Attack under 65 y/o					
Diabetes					
High Cholesterol					
Stroke					
Suicide					
Bipolar Disorder					
Depression					
Anxiety					
Thyroid Disease					
Alzheimer's					
Kidney Disease					
Osteoporosis					
Age					
Age at death					
Cause of Death					

Family: Are you presently : Married Never Married Divorced Widowed

I've been in my current status since: _____ How many marriages? _____ How many divorces? _____

Who are you currently living with? Spouse Friend Roommate Family Member Alone

How many children do you have? _____ What states do they live in? _____

Social History: Hobbies / Interests _____ Exercise _____

Habits: Nicotine □ ETOH (Alcohol) □ Caffeine □ Recreational Drugs □

Advanced Directives:

Do you have an updated Will? No Yes Do we have copies of your Advanced Directives? No Yes

Medications: _____ _____
_____ _____
_____ _____

Vitamins / Supplements: _____
Allergies: _____

Annual Review/ Personal Medical History

Name:_____ Date:_____

Please review the items below and mark those that have appeared during the last 12 months only.
Make comments regarding those you marked in the space below.

CONSTITUTIONAL		GASTROINTESTINAL (cont.)		METABOLIC / ENDOCRINE (cont.)	
Chills		Heartburn		Change in Appetite	
Fatigue		Loss of Appetite		NEUROLOGICAL	
Fever		Nausea		Dizziness	
Malaise		Vomiting		Extremity Numbness	
Night Sweats		GENITOURINARY		Extremity weakness	
Weight Gain		Dribbling		Gait Disturbance	
Weight Loss		Painful Urination		Headache	
EAR NOSE AND THROAT		Blood in Urine		Memory Loss	
Ear Drainage		Increased Urine Volume		Seizures	
Ear Pain		Slow Stream		Tremors	
Eye Discharge		Urinary Frequency		PSYCHIATRIC	
Eye Pain		Urinary Incontinence		Anxiety	
Hearing Loss		Urinary Retention		Depression	
Nasal Drainage		REPRODUCTION (FEMALE)		Insomnia	
Sinus Pressure		Abnormal Pap		SKIN	
Sore Throat		Breast Discharge		Contact Allergy	
Visual Changes		Breast Lump		Hives	
RESPIRATORY		Menstrual Cramps		Itching	
Chronic Cough		Pain with Intercourse		Mole Changes	
Cough		Hot Flashes		Rash	
Known TB exposure		Irregular menses		Skin Lesion	
Shortness of Breath		REPRODUCTION (MALE)		MUSCULOSKELETAL	
Wheezing		Erectile dysfunction		Back Pain	
CARDIOVASCULAR		Penile discharge		Joint Pain	
Chest Pain		Sexual Dysfunction		Joint Swelling	
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Edema		Brittle Hair		Neck Pain	
Palpitations		Brittle Nails		HEMATOLOGICAL/LYMPHATIC	
GASTROINTESTINAL		Cold Intolerance		Easy Bleeding	
Abdominal Pain		Hair Changes		Easy Bruising	
Blood in Stools		Heat Intolerance		IMMUNOLOGIC	
Change in Stools		Increased Body Hair		Environmental Allergies	
Constipation		Increased Thirst		Food Allergies	
Diarrhea				Seasonal Allergies	

Have you had surgery this year?		Have you updated your Will this year?	
Were you hospitalized this past year?		Have you made out Advanced Directives?	
Have you had to visit the ER this year?		Do you have an exercise program?	
Do you feel unsafe driving a car?		Did you start or quit smoking this year?	
Any new major disease in your family?		Do you need to cut down on alcohol?	
Did you get a flu shot this past year?		Do you use marijuana, cocaine or meth?	
Did you get any other shots this year?		Were you married or divorced during the year?	
Do you take a multivitamin?		Did you move during the year?	
At any time have you felt afraid of your partner?			

Comments on the above or other concerns you might have: _____

_____

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_____

_____

Annual questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

Alcohol: One drink = 12 oz. beer 5 oz. wine 1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

Tobacco:

Have you ever used tobacco? ○ No / Never ○ Yes ○ Previously / Quit
If yes, what type?

○ Cigarette ○ Pipe ○ Cigar ○ Chewing ○ Other – please specify _____
○ Daily Use?
○ Quantity per day _____ How many years _____
○ Age started _____ Age Stopped _____

Are you exposed to second hand smoke? ○ Environmental (home) ○ Occupational (work)

WEST SALEM FAMILY PRACTICE ASSOCIATES, LLC
1275 Wallace Road N.W. • Salem, Oregon 97304 • (503) 371-3232 • Fax (503) 375-2398

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Full Name_____ Date of Birth _____

Street Address _____ Social Security # (Last 4 digits) _____

City, State, Zip Code_____ Phone/Cell Number _____

Release Health Information from:	Release Health Information to:
_____	_____
_____	_____
_____	_____
Phone/Fax _____	Phone/Fax _____

I consent to have all information faxed from/to the above facility/clinic. ____Yes ___No Transfer of care ____Yes ____No

Which Information do you wish to have released? Dates of Service: From_____ To_____

___3 years of chart notes	___All Cardiology reports/testing
___3 years of Laboratory	___All Pulmonary reports/testing
___All Pathology	___All Ophthalmology reports/testing
___All Radiology	___All Operative reports/discharge summaries

The following PHI <u>will not</u> be released or copied unless you indicate by initialing:

___ AIDS/HIV (Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus)

___Mental Health (Psychiatric Care and/or Psychological Assessments)

___Treatment for Alcohol and/or Drug Abuse

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for _____ months from the date of signature.

I understand that I may cancel this request at any time with written notification but that it will not affect any information release prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulation. I understand and accept the statements contained in the authorization.

_____ _____

Signature of individual (or guardian or Person Representative of patient's estate) Date

Copy charges may be assessed in accordance with Oregon State Law.

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Alcohol abuse					
Arthritis/Gout					
Bleeding Disorder					
Colon Cancer					
Breast Cancer					
Prostate Cancer					
Glaucoma					
Heart Attack under 65 y/o					
Diabetes					
High Cholesterol					
Stroke					
Suicide					
Bipolar Disorder					
Depression					
Anxiety					
Thyroid Disease					
Alzheimer's					
Kidney Disease					
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Were you hospitalized this past year?		Have you made out Advanced Directives?	
Have you had to visit the ER this year?		Do you have an exercise program?	
Do you feel unsafe driving a car?		Did you start or quit smoking this year?	
Any new major disease in your family?		Do you need to cut down on alcohol?	
Did you get a flu shot this past year?		Do you use marijuana, cocaine or meth?	
Did you get any other shots this year?		Were you married or divorced during the year?	
Do you take a multivitamin?		Did you move during the year?	
At any time have you felt afraid of your partner?			

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_____

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_____