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/social 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.

Current Chronic Conditions

_____

_____

Surgeries/Hospitalizations: Dates:

_____

_____

Medications: _____ _____ _____

_____ _____ _____

_____ _____ _____

Vitamins/Supplements: _____

Other providers / Specialists / Ongoing Therapies _____

Allergies: _____

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

Condition	Father	Mother	Grandparents	Siblings	Children
Allergy/Asthma					
Alcohol Abuse					
Arthritis/Gout					
Bleeding Disorder					
Colon Cancer					
Breast Cancer					
Prostate Cancer					
Glaucoma					
Heart Attack under 65					
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: _____

Do you have an updated Will? Yes No Do we have copies of your Advance Directive? Yes No

Childbirth: Pregnancies___ Miscarriages ___ Abortions ___ Births ___

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	
Leg Pain with Exercise		METABOLIC / ENDOCRINE		Muscle Weakness	
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: _____

_____

_____

_____

_____

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.

West Salem Family Practice Associates, LLC

ACKNOWLEDGMENT AND CONSENT TO USE/DISCLOSE PROTECTED HEALTH INFORMATION (HIPAA)

PATIENT NAME (PLEASE PRINT) _____ DATE OF BIRTH _____

I understand that West Salem Family Practice Associates, LLC (WSFPA) will use and disclose health information about me. I understand that this may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health, history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

I understand and agree that WSFPA may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how WSFPA will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, physicians and other personnel of WSFPA, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of the Notice of Privacy Practices upon my request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that WSFPA is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and, if I requested, that I have received a copy of the Notice of Privacy Practices.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____ **TODAY'S DATE** _____

I would also like to give permission for _____ to:
PLEASE PRINT NAME OF FAMILY MEMBER OR REPRESENTATIVE

Discuss information regarding my appointments, my account balances, my medical conditions, including results, printing and release of medication lists, and to leave phone messages on my listed phone number with this person or on voicemail of which they may have access.

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PLEASE PRINT & COMPLETE ALL ENTRIES

Patient's Legal Name (Last-First-Middle Initial)	Patient's Maiden Name	Sex ☐M ☐F	Driver's License Number
Address City State		Zip Code	Home Phone ( )
Mailing Address, if Different From Above State		Zip Code	Cell Phone ( )
First name you prefer to be called by:	E-mail address:		
Race: (optional) ☐ Caucasian ☐ Native American ☐ Latino ☐ Asian ☐ African American ☐ Other			
Marital Status (please check one) ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed	Social Security Number	Age	Birth Date
Patient Employed By			Employer Phone ( )
Responsible Party or Spouse Information (if Different from Above)	Birth Date		Home Phone ( )
Employed By			Employer Phone ( )
Do you have Medical Insurance? ☐ No ☐ Yes	Is Today's Visit Work Related or the Result of a Motor Vehicle Accident? ☐ No ☐ Yes		If yes, Date of injury?
Name of Primary Insurance (Provide copy of ID card to attach)			
Name of Policy Holder	Policy Holder's Date of Birth	Group Number	ID Number, Including Alpha Letters
Do you have Secondary Medical Insurance? ☐ No ☐ Yes	Name of Secondary Insurance (Provide copy of ID card to attach)		
Name of Policy Holder	Policy Holder's Date of Birth	Group Number	ID Number, Including Alpha Letters
Emergency Contact	Phone ( )		Relationship

INSURANCE AUTHORIZATION AND ASSIGNMENT

ASSIGNMENT AND RELEASE

I, the undersigned, have health insurance with: _____

Name of Insurance Company

and assign all medical insurance benefits directly to West Salem Family Practice Associates or its physicians.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

I have also been notified of the Missed Appointment Policy and understand that I am financially responsible for all charges under this policy.

_____ _____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to WSFPA/Dr. _____ for any services furnished by this doctor. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information to pay the claim. If "other health insurance" is indicated on any approved CMS claim form or electronically submitted claim, my signature authorizes the release of the information to the insurer or agency shown.

_____ _____

Beneficiary Signature Date

February 2003

WEST SALEM FAMILY PRACTICE ASSOCIATES, LLC

Mark Scherlie DO, Eugene Yamaguchi MD, Amanda Mehlhoff FNP

Paul Weaver DO, Heidi Thomas MD, Scott Bean MD

Family Physicians and Surgeons

1275 Wallace Road NW, Salem, Oregon 97304 *(503) 371-3232, Fax: (503) 375-2398*

FINANCIAL AGREEMENT

West Salem Family Practice Associates, LLC, thanks you for choosing us as your health care provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful patient-provider relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that patient-provider relationship and our goal is to not only inform you of the provisional aspects of that financial policy, but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact our Billing Office at (503) 371-0145. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the patient-provider relationship. You will be asked at every check in to sign our encounter form which states that you will be financially responsible for your visit regardless of insurance coverage. This is our policy and your signature is required ***before*** services will be rendered. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service. If you do not have health insurance coverage, you will be responsible for paying $50 at the time of check in, and if you choose to pay the remainder of the balance at the end of your visit, we will give you a 25% discount on your services. If you are unable to pay the remainder of the balance on the same business day, you will be billed the remainder of your visit, without the discount, and payment in full will be required within 30 business days from the date of service.

We make payment as convenient as possible by accepting cash, money order, MasterCard, Visa, Discover, American Express and in-state checks. A $25.00 service fee will be charged for all return checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advanced or cancel with less than 24 hours' notice, a missed appointment/late cancellation fee may apply. These fees are typically $25-$50 but could be up to the actual cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, authorization and referral information, if required, and to notify our office of any information changes when they occur. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments at the time of service, co-insurance and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

It is also your responsibility to verify that services that you receive at our office are covered by your insurance carrier and, if not covered, that you will take financial responsibility for receiving non-covered services.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files, and or summaries.

I have read and understand the above financial policy. I agree to assign insurance benefits to West Salem Family Practice Associates, LLC whenever applicable. I also agree, in addition to the amount owed, I will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

*Signature of Insured or Authorized Representative: _____

*Please print your name: _____

*Date signed: _____

*Additional family members (if any) on your account for which you are financially responsible:

_____