DESCHUTES
FAMILY CARE

Welcome to Deschutes Family Care
New Patient Information, HIPAA, & Consent for Treatment

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Date _____

Patient Information

Name (legal):_____ "_____"
First Middle Last Preferred Name

Date of birth:_____ Gender: □ Male □ Female □ other _____

Mobile Phone:_____ Email:_____

Approved communications/notifications: □ Mobile text (SMS) □ Voicemail □ Email □ None

Home Phone:_____ Work Phone:_____

Preferred contact method: □ Phone (Mobile / Home / Work) □ Email □ Mail □ Other_____

Address: _____

City: _____ State: _____ ZIP: _____

Occupation: _____

Other Doctors/Specialist/Treatments: _____

Referred by: _____

Information on Responsible Party (parent/guarantor)

□ **Check here if self** and skip this section—

Name:_____ Date of birth: _____
First Middle Last

Home address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Relationship to patient: _____

Insurance information
No insurance billing is allowed for services provided under the retainer medical agreement

1st insurance company	Policy #	Group #	Subscribers Name and DOB
2nd insurance company	Policy #	Group #	Subscribers Name and DOB

Deschutes Family Care

Notice of Privacy Practices Acknowledgment Form (HIPAA)

_____**(initial)** I acknowledge that I have been offered or received a copy of the **Deschutes Family Care** Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment from Deschutes Family Care, Deschutes Family Care may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as otherwise necessary for the operations of Deschutes Family Care. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by Deschutes Family Care that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting Deschutes Family Care to make such a request. I also understand that I have the right to request Deschutes Family Care to restrict how my health information is used or disclosed. Deschutes Family Care does not have to agree to my request for the restriction, but if Deschutes Family Care does agree, Deschutes Family Care is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that Deschutes Family Care has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment maybe withdrawn if I withdraw my consent.

_____ _____

Signature Date

Contacts

I, _____, choose to designate the individuals listed below as my primary contacts. Deschutes Family Care personnel may share information with these primary and other contacts that is consistent with the Notice of Privacy Practices.

□ **Check here if there are NO contacts**

Primary Contact: _____ _____ _____
Name Relationship Phone

Emergency Contact: □ Same as above

_____ _____ _____
Name Relationship Phone

Other Contact: _____ _____ _____
Name Relationship Phone

Other Contact: _____ _____ _____
Name Relationship Phone

—Provider may retrieve all of patient's prescription history from pharmacies?

□ **Yes** □ **No**

* *** * * * *** * *** * *** * * * *** *

****MEDICARE ONLY****

Medicare cannot be billed for services provided under the retainer medical agreement

Medicare lifetime consent: I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____ _____
Signature Date

****PATIENT'S REPRESENTATIVE****

It was not possible to obtain the individual's acknowledgement for the following reason(s):

□ Emergency situation
□ Patient physically unable to sign
□ Patient refused
□ Patient left office prior to obtaining signature
□ Other reason:_____

Name _____Relationship: _____
Comments _____
Signature of representative _____ Date _____