COLUMBIA CLINIC & URGENT CARE
82nd Avenue

Patient Registration

Patient Information

Reason(s) for today's Visit: _____

Last Name: _____ **First Name:** _____ **MI** _____

Preferred Name: _____ **Former Last Name** (*optional*)**:** _____

Name of Parent/Legal Guardian (*if applicable*)**:** _____

Phone Number of Parent/Legal Guardian (*if applicable*)**:** _____

Date of Birth (*mm/dd/yy*)**:** _____ **Gender Assigned at Birth:** _____

Do you speak and understand English? ☐ Yes ☐ No **Preferred Language:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated ☐ Unknown

Patient Contact Information

Home Phone: _____ **Cell Phone:** _____

Do you consent to receive text messages? ☐ Yes ☐ No

Email Address: _____

May we email you a link to register for our patient portal? ☐ Yes ☐ No

Mailing Address: _____ **Apt./Unit:** _____

City: _____ **State:** _____ **Zip Code:** _____

Patient Demographic Optional Information

Race: _____ **Ethnicity:** _____ **Sexual Orientation:** _____

Gender Identity: _____ Pronouns: _____

Emergency Contact Information

Emergency Contact Name: _____ **Phone Number:** _____

Relationship to Emergency Contact: _____

Please continue to the next page

Additional Optional Information

How did you hear about our clinic? _____

Are you interested in establishing care with Columbia Medical Clinic, P.C.? ☐ Yes ☐ No

Authorization to Release Information

To protect your Protected Health Information (PHI), Columbia Medical Clinic, P.C. will not release any medical information to any person without your written consent. Additionally, patients will not be able to receive hard copies of their own information without prior written consent.

Restrictions: I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Do you authorize the release of the following Protected Health Information (PHI) to yourself? ☐ Yes ☐ No

☐ All Routine Records	☐ Genetic Testing Records	☐ Contraception Records
☐ Billing Records	☐ Mental Health Records	☐ Pregnancy Test Records
☐ HIV/AIDS Related Records	☐ Drug/Alcohol Use Records	☐ STI records

I authorize the release of the following Protected Health Information (PHI) to:

Name: _____ Relationship: _____ Phone: _____

☐ All Routine Records	☐ Genetic Testing Records	☐ Contraception Records
☐ Billing Records	☐ Mental Health Records	☐ Pregnancy Test Records
☐ HIV/AIDS Related Records	☐ Drug/Alcohol Use Records	☐ STI records

Note: Additional authorization forms are available upon your request.

Is there any additional information that you would like to share with the provider today?

_____ _____

Signature of Patient or Parent/Legal Guardian **Date**

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HIPAA Notice of Privacy Practices

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, Columbia Medical Clinic, P.C. creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and clinical information to my bill
- A means by which a third-party payer (e.g. insurance carrier) can verify that the services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and outcomes.

Use of Email and Protected Health Information (ePHI)

Email messages allow health care providers and staff to exchange information efficiently for the benefit of our patients. At the same time, we recognize that email messages are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or transmission. Our emails systems encrypt messages using Transport Layer Security (TLS), providing a secure email option between our work stations and the server of your personal email provider. Since not all providers offer encryption as a standard service, your information may be improperly accessed during this part of the transmission. Columbia Medical Clinic, P.C. and our partners cannot be held liable for a data breach after the information has left the servers of our email system. Patients have the right to send and receive ePHI but must acknowledge and assume the risk involved.

Do you want Columbia Medical Clinic, P.C. to send your Protected Health Information via email? ☐ Yes ☐ No

If yes, please select the specific types of information that you authorize for transmission via email.

☐ All Routine Records	☐ Genetic Testing Records	☐ Contraception Records
☐ Billing Records	☐ Mental Health Records	☐ Pregnancy Test Records
☐ HIV/AIDS Related Records	☐ Drug/Alcohol Use Records	☐ STI records

Use of Voicemail and Protected Health Information (PHI)

Our providers and staff may, from time to time, be unable to reach you by telephone to relay health care related information such as lab results, imaging results, etc. Because others may have access to listen to your voicemail, your expressed consent is needed to leave a detailed message.

Do you consent to receive detailed voice messages via telephone containing PHI? ☐ **Yes** ☐ **No**

State Registry

I understand that Columbia Medical Clinic, P.C. is required under Oregon law to share my immunizations records to the State Registry which is accessible among all providers in the state.

Acknowledgement

I have reviewed and understand Columbia Medical Clinic, P.C.'s Privacy Practices

_____ _____
Name of Patient (*please print*) Date of Birth

_____ _____
Signature of Patient or Parent/Legal Guardian Date

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Assignment of Insurance Benefits

Last Name: _____ **First Name:** _____ **DOB** _____

Medical Insurance Information

Primary Insurance Company: _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:** _____

The policy holder is: □ **Self** □ **Spouse** □ **Parent** □ **Other:** _____

Insurance ID #: _____ **Policy Group #:** _____

Secondary Insurance Company: _____

Name of Policy Holder: _____ **Policy Holder Date of Birth:** _____

The policy holder is: □ **Self** □ **Spouse** □ **Parent** □ **Other:** _____

Insurance ID #: _____ **Policy Group #:** _____

Insurance Waiver

I understand that insurance is considered a method of reimbursing the patient for fees paid to the provider, but is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for services, it is ultimately my responsibility to determine what coverage I have and to pay the portion of the bill not covered by my insurance company (unless otherwise restricted by law or an agreement CMC may have with the insurer).

I understand that Columbia Medical Clinic, P.C. (CMC) reserves the right to require a deposit, above my required copay, for services not routinely covered and that any unapplied portion of my deposit will be refunded.

I understand that late fees will be applied if my account becomes past due and that delinquent accounts will be sent to collection. I further understand that future services may be halted until my account becomes current. I acknowledge that there may be payment plans available to me and that it is my responsibility to contact the billing department to make these arrangements.

Please continue to the next page

I understand that some types of visits may result in me receiving separate bills for charges such as lab tests and/or certain medical supplies. I acknowledge that these services are provided by non-CMC affiliated vendors and that any questions or disputes over this billing will be handled directly with that vendor.

I understand that I may be charged $100 for any appointment that I cancel with less than 24 hours notice or do not show up for without notification.

Insurance Disclaimer

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service.

I understand that my health insurance company may deny payment for the services identified above and for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

I authorize the holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Acknowledgement

I have read, understand and agree to the above statements made in the insurance waiver and disclaimer.

_____ _____

Name of Patient (*please print*) Date of Birth

_____ _____

Signature of Patient or Parent/Legal Guardian Date