Springfield Wellness Center

Patient Demographics

Today's Date:____________________________

Patient Name:____________________________ DOB:__________________ Gender: M / F / Other

Address:__________________________ City:__________________ State:______Zip:______________

Home PH #:____________________________________ Cell PH#:______________________________

Work #:_______________________________________E-Mail:__________________________________

Would you like to be enrolled in the Patient Portal? ☐ Yes ☐ No

Can we Leave Message? ☐ Home # ☐ Cell # ☐ Work #

48-Hour Reminder Call: ☐ Phone Call ☐ Text Message

Emergency Contact:_______________________ Phone:________________Rel:_______________

Relationship Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Race (optional): ☐ White ☐ Asian ☐ Hispanic ☐ Pacific Islander ☐ Black / African American

☐ American Indian / Alaska Native ☐ Other ☐ Prefer Not to Say

Ethnicity (Optional): ☐ Not of Hispanic / Latino Origin ☐ Hispanic / Latino Origin ☐ Prefer Not to Say

Preferred Language: ☐ English ☐ Spanish ☐ Other:______________________________________

Primary Care Provider (PCP):____ ☐ No PCP

Preferred Pharmacy:_______________________Location:_______________________________

Please indicate if you are:

☐ **City of Springfield** ☐ Active ☐ Dependent		☐ **Springfield School District**	
☐ IAFF ☐ AFSCME ☐ OPEU-SEIU	☐ SPA ☐ Non-Rep ☐ Retiree	☐ Active ☐ Retiree	☐ Active Dependent ☐ Retiree Dependent

If patient is a minor:

Mother's Name:______________________________ DOB:______________Phone#:_______________

Home Address: ☐ Same as above ____

Fathers Name:_______________________________DOB:______________Phone#:_______________

Home Address: ☐ Same as above ____

<u>INSURANCE INFORMATION</u>

PRIMARY Insurance Name:				
Group #:	ID #:		Ph#:	
Policy Holder:		DOB:		Employer:

SECONDARY Insurance Name:				
Group #:	ID #:		Ph#:	
Policy Holder:		DOB:		Employer:

Conditions for Receiving Services
Springfield Wellness Center

MEDICAL CONSENT: I voluntarily request and consent to the medical care provided by Cascade Health. I understand my medical care and treatment is under the management of the attending medical service provider. This organization assumes no liability for any act or omission in following the instruction(s) of said provider. The undersigned consents to any diagnostic imaging and/or laboratory procedures, medical treatments, or other services rendered under the general and/or special instruction of the provider. The attending medical provider will explain the need for such treatments, procedures and/or services to allow the patient to make an informed decision regarding care. I understand that if I need specific services not provided by the agency, such services must be arranged by the patient, or legal representative. The agency shall in no way be responsible to provide the same.

CONSENT TO RELEASE HEALTH INFORMATION: I consent to allow Cascade Health to furnish any part of my medical record to any person or company, agency, or other authorized party responsible for all or part of my healthcare charges. By giving consent, I understand the requestor may have access to otherwise confidential information contained within my medical record. If I choose to not release my health information, I understand and agree I will pay for all my healthcare charges in the event payment is denied.

SPECIAL CONSENT: I understand my medical record may contain information specific to drug/alcohol abuse and/or addiction, and/or psychiatric conditions, and/or HIV testing, and/or HIV positive diagnosis, and/or genetic testing. Such diagnosis and treatment information may not be released without my specific consent. I consent to allow such information to be given to any person, corporation, agency, or other authorized party responsible for all or part of my healthcare charges. I can withdraw my consent at any time. My consent is valid for this service event only and when the billing process is complete, it lapses.

CONSENT FOR REVIEW OF MEDICAL RECORD BY FEDERAL/STATE AGENCIES AND OTHER AUTHORIZED AUDITING AND REVIEW AGENCIES: I understand there are federal/state and other agencies who are required to review, and on occasion, copy parts of my medical record for the purpose of assuring an acceptable standard of medical care and charges for my healthcare services are correct as stated. I consent to review of my medical record for these purposes alone.

IF THE PATIENT IS A MINOR OR LEGALLY INCOMPETENT TO SIGN FOR HIS/HER OWN MEDICAL CARE, THE PARENT OR LEGAL GUARDIAN MAY SIGN IN HIS/HER PLACE FOR ANY OF THE ABOVE CONSENTS.
FINANCIAL AGREEMENT: The undersigned agrees, whether he/she signs as agent or patient, that in consideration of the services to be rendered to the patient, he/she hereby obligates him/herself to pay the account of Cascade Health in accordance with the rates and terms of the organization. Should the account be referred to an attorney or collection agency for collection and/or suit, the undersigned shall pay reasonable attorney's fees and collection expense.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Cascade Health and/or its agents of the group or personal benefits or any other insurance benefits otherwise payable to me, for this period of service. I understand I am financially responsible to Cascade Health for charges not covered by this assignment. A photocopy of this authorization shall be considered as effective and valid as the original.

PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information to release sufficient information regarding my diagnosis or treatment for billing purposes. I request payment of authorized benefits be made on my behalf. I assign the benefits payable for 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. I understand I am financially responsible to Cascade Health for charges not covered by this assignment.

ACKNOWLEDGEMENT OF EPRESCRIBING

I agree that Springfield Wellness Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors, for treatment purposes.

Initials______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices of Cascade Health describes how my health information may be used and shared, and how I may obtain access to my health information. I understand that the organization has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Privacy Officer at 541-228-3056.

I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

Initials______________

ACKNOWLEDGEMENT OF RECEIPT OF GENETIC RESEARCH OPT-OUT NOTIFICATION AND OPT-OUT STATEMENT

I have received a copy of CH's Genetic Research Opt-out notification and Opt-out Statement form that allows me to opt out of future anonymous or coded genetic research. I understand that CH has the right to change this Notice at any time. I may obtain a current copy of the Genetic Research Opt-out notification and Opt-out statement form by contacting the Privacy Officer, at 541-228-3000.

By signing below, I acknowledge that I have been provided a copy of the Genetic Research Opt-out notification and Opt-out statement form.

Initials______________

A COPY OF THIS "CONDITIONS FOR RECEIVING SERVICES" FORM IS AVAILABLE UPON REQUEST.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, AND IS THE PATIENT, OR DULY AUTHORIZED BY THE PATIENT AS THE PATIENT'S AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

______________________________	______________________________
DATE	PATIENT
______________________________	______________________________
PATIENT'S AGENT OR REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and/or Genetic Research Opt-out notification and Opt-out Statement form, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)______________________________

Family/Friends Release of Information Authorization to Use/Disclose Protected Health Information

AUTHORIZATION: *For collaboration purposes, I authorize:* ***Springfield Wellness Center*** *to release my health information regarding my care, including any areas I have identified below, with the individual recipient listed.*

NAME, PHONE AND DOB OF SPRINGFIELD WELLNESS CENTER PATIENT

Patient Name:_______________________________ Ph#:_________________ DOB:_______________________

NAME OF AUTHORIZED INDIVIDUAL RECIPIENT, PHONE AND RELATIONSHIP TO PATIENT

Name:____________________________________ Ph#:__________________ Relationship:_______________

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
______Genetic Testing
______Alcohol / Chemical Dependency Diagnosis, Treatment or Referral Information
______Mental Health Information
______Sexually Transmitted Disease

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and will no longer be protected under federal law. ***However, I also understand that federal law restricts re-disclosure of alcohol and chemical dependency diagnosis, treatment, or referral information and specifically requires my authorization prior to re-disclosure.***

PATIENT 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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.*

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 the Cascade Health Compliance Officer at 2650 Suzanne Way, Suite 200, Eugene, OR 97408 and state you are revoking this authorization.
Unless revoked, this authorization expires: ____
(INSERT EITHER APPLICABLE DATE OR EVENT)

I have read this authorization, I understand it, and agree to the use/disclosure as outlined.

Signature:____ Date:_______________________________
(INDIVIDUAL OR PERSONAL REPRESENTATIVE)

Description of personal representative's authority: ____

Springfield Wellness Center
Health History Questionnaire

Date of Exam:___________________________

Patient Name:____ **DOB:**______________ **Sex:** **Male/ Female**

Reason for seeking medication attention:____

Other doctors involved in my care:____

Personal Medical History: Have you **EVER** been diagnosed with the following? (*Check all that apply*)

Heart Disease	Lung Disease	Musculoskeletal	General
☐ Murmur	☐ Emphysema	☐ Gout	☐ Paralysis
☐ Angina	☐ Asthma	☐ Rheumatoid Arthritis	☐ Bleeding Disorder
☐ Congestive Heart Failure	☐ Chronic Bronchitis	☐ Muscle/Joint Disorder	☐ Glaucoma
☐ Rheumatic Fever	☐ Pneumonia		☐ Cancer
☐ Bypass Surgery	☐ Cancer	**Kidney / Bladder**	☐ Anxiety
☐ Valve Replacement	☐ Asbestosis	☐ Stones	☐ Depression
☐ Heart Infection		☐ Prostate Disorder	☐ Mental Illness
☐ Irregular Heartbeat	**Gastrointestinal**	☐ Incontinence	☐ Alcoholism
☐ Heart Attack	☐ Polyps	☐ Infection	☐ Drug Abuse
	☐ Gallstones		☐ Blood Transfusion
Infection Disease	☐ Hiatal Hernia	**Skin**	☐ Congenital Disorder
☐ AIDS or HIV Positive	☐ Hemorrhoids	☐ Disorder	☐ High Blood Pressure
☐ TB	☐ Irritable Bowell Synd.		☐ Diabetes
☐ STD	☐ Spastic Colon	**Screening**	☐ High Cholesterol
	☐ Colitis	Mammogram	☐ Migraines
Gynecological	☐ Diverticulosis	Date:	☐ Anemia
☐ Abnormal Pap	☐ Cancer	Colonoscopy	☐ Thyroid Problem
☐ Cancer	☐ Bleeding	Date:	☐ Seasonal Allergies
☐ Endometriosis	☐ Ulcers	Prostate	☐ Stroke
☐ Fibroids		Date:	☐ Seizure Disorder
☐ Cysts		PAP	
☐ Irregular Bleeding		Date:	

Please provide dates and/or other comments about the above history:____

____

Hospitalizations, Operations, Injuries, Accidents and Serious Illnesses (list since previous physical, or if not previously listed. Omit pregnancies)			
Describe	**Year**	**Describe**	**Year**
1.		3.	
2.		4.	

Medications (include Non-prescription drugs, herbs and vitamins)			
Current Medication	**Dosage**	**Current Medication**	**Dosage**
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Allergies (include adverse reactions to medicine, food, materials, etc.)			
Allergy	**Reaction**	**Allergy**	**Reaction**
1.		3.	
2.		4.	

Family History	Father	Mother	Father's Mother	Father's Father	Mother's Mother	Mother's Father	Siblings	Children
A = Alive **D = Deceased**	☐ **A** ☐ **D**	☐ **A** ☐ **D**	☐ **A** ☐ **D**	☐ **A** ☐ **D**	☐ **A** ☐ **D**	☐ **A** ☐ **D**	☐ **A** ☐ **D**	☐ **A** ☐ **D**
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
TB	☐	☐	☐	☐	☐	☐	☐	☐

Male Health History ♂

☐ History of sexually transmitted disease?______________________________ ☐ Discharge from penis?

☐ Testicular pain? ☐ Lumps in testicles or scrotum? ☐ Decrease in testicular size? ☐ Decrease in sexual desire?

☐ Decreased ability in achieving erection? Do you have concerns about your sex life? ☐ **Y** ☐ **N**

Female Health History ♀

Age of onset of menstrual periods: Date of last period: Date of menopause:

Date of last PAP: Have you had abnormal PAPS? ☐ **Y** ☐ **N** Date:

Have you ever bleed between periods? ☐ **Y** ☐ **N** Have you had vaginal bleeding since menopause? ☐ **Y** ☐ **N**

Heavy vaginal discharge? ☐ **Y** ☐ **N** Menstrual pain? ☐ **Y** ☐ **N** Hot Flashes? ☐ **Y** ☐ **N**

☐ History of sexually transmitted disease:____________________ ☐ Decrease ☐ Increase in sexual desire?

Do you have a history of: ☐ Endometriosis ☐ Ovarian growths ☐ DES exposure ☐ Infertility ☐ Fibroids

Number of pregnancies: Live births: Miscarriage(s): Current contraception being used? ☐ **Y** ☐ **N**

Social History

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow | **Occupation:**

Living Situation: ☐ Alone ☐ Roommate ☐ Spouse ☐ Parents ☐ Significant Other ☐ With Children

Are you currently or have you ever been in a relationship where you were hurt, threatened, or made to feel afraid?	☐ **Y** ☐ **N**

Preventive Health Status

Date of last Physical Exam: Date of last Eye Exam:

Do you exercise regularly? ☐ **Y** ☐ **N** Type: How often?

Do you follow a special diet? ☐ **Y** ☐ **N** Describe:

Do you use tobacco? ☐ **Y** ☐ **N** How much / How long? ☐ Quit - When?

Do you drink alcohol? ☐ **Y** ☐ **N** How much / How long? ☐ Quit - When?

Do you drink caffeine? ☐ **Y** ☐ **N** How much / How long? ☐ Quit - When?

Have you used illicit drugs? ☐ **Y** ☐ **N** Which ones?

Do you use Marijuana? ☐ **Y** ☐ **N**

Springfield Wellness Center
In partnership with Cascade Health

225 Fifth Street, Ste 518, Springfield, OR 97477

Patient Sticker

Patient Name: ____ Exam Date: _______________________

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns.
During the past two weeks: have you often been bothered by any of the following problems?

Little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

Feeling down, depressed, irritable or hopeless?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

If you answered YES to either of the above questions please turn this over and answer the additional questions.

If you answered NO to both questions you are done with this questionnaire.

If you answered "Yes" to either question on the front page - please answer all questions below.

During the past two weeks, how often have you been bothered by any of the following problems? Place an **"X"** in the box beneath the answer that best describes how you have been feeling.	**(0)** **Not At All**	**(1)** **Several Days**	**(2)** **More than Half the Days**	**(3)** **Nearly Every Day**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, irritable or hopeless				
3. Trouble falling or staying asleep or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite, weight loss, or overeating				
6. Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, like reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				

10. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult