2700 SE Stratus Ave Suite 201 McMinnville, OR Phone: 503-435-6398 Fax: 503-435-6396

Patient's Name:		Patient's Birthdate:		Patient's Sex:
Patient's former or previous names:		How did you hear about us:		
Primary Care Provider and Phone Number:		Referring Provider and Phone Number:		
Home Phone Number	Cell Phone Number:	Patient's SSN:	Marital Status (circle one): Single Married Widow Divorced	
Email Address:		**Carehome/Facility address and phone number:**		
Street Address:		City:	State:	Zip Code:
Mailing Address if different:		City:	State:	Zip Code:
Preferred Language:	Ethnicity and Race (circle one): White/Caucasian Hispanic/Latino American Indian Asian African American/Black Other:			
Preferred Communication Method (circle one): **Phone Call:** __ Cell Number or __ Home Phone **Text Message** **Patient Portal Message** **Email**(Appointment/Billing only)				
Employment Status (circle one): Full Time Part Time Unemployed Self-employed Student Active Military Retired Disabled				
Employer:	Employer Address:			
Patient/Guardian Information if Under 18 years of age/Person consenting to treatment (Responsible Party):				
Parent/Guardian:	Address if different from above:	Date of Birth:	Relationship to Patient:	
INSURANCE INFORMATION – PLEASE PROVIDE INSURANCE CARD TO THE RECEPTIONIST				
Primary Insurance Plan Name:		Policy Holder's Name:		
Policy Holder's Date of Birth:	Relationship to Patient:	Policy Holder's Employer:		
Insurance ID Number:		Group Number:		
Secondary Insurance Plan Name:		Policy Holder's Name:		
Policy Holder's Date of Birth:	Relationship to Patient:	Policy Holder's Employer:		
Insurance ID Number:		Group Number:		
Workers Compensation and/or Motor Vehicle Claim information				
Carrier Name:		Billing Address:		
Claim #	Adjuster Name:	Adjuster Phone Number:	Adjuster Fax Number:	
Date of Injury:	Body Part	Employer:		

2700 SE Stratus Ave Suite 303 McMinnville, OR Phone: 503-435-4520 Fax: 503-474-9430
WillametteValleyClinics.com

Patient Name:	Date of Birth:	
Under the Health Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to family member or other persons identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the medical record.		
The following designated parties have AUTHORIZATION to my health information, written physical prescriptions, and are my emergency contacts:		
1. Primary Emergency Contact & Designated Party:	Relationship to Patient:	Phone Number:
2. Designated Party Name:	Relationship to Patient:	Phone Number:
3. Designated Party Name:	Relationship to Patient:	Phone Number:

Notice of Privacy Policy:	
I acknowledge that I have been given Willamette Valley Clinic's of Privacy Practices (available at front desk). I understand that if I have questions or complaints I may contact the facility Privacy Official.	Initial Here:
Insurance Signature on File and Assignment of Benefits	
I request the payment of authorized insurance benefits be made on my behalf to Willamette Valley Clinics, LLC for any services furnished to me by clinic providers. I authorize any holder of medical information about me to release to the insurance carrier 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 necessary to pay the claim, this includes Medicare, Medicaid, private insurance, and other health plans.	Initial Here:
Additional Authorizations and Acknowledgements	
Authorizations for the Release of Medical Information: I consent to the treatment necessary for the patient named on this document. I authorize the release, via fax if necessary, of all medical records, including any and all records containing HIV, substance abuse and/or mental health, to the referring and family physician and to my insurance company, if applicable.	Initial Here:
Assignment of Benefits: In consideration of any and all medical services, care, drugs, supplies furnished by Willamette Valley Clinics, LLC and providers. I hereby irrevocable transfer to Willamette Valley Clinics, LLC, all insurance benefits due and payable to me and/or surgical services rendered by providers for whom Willamette Valley Clinics, LLC is authorized to charge and bill. I understand and agree (regardless of insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I will also pay all costs and expenses of collection. I hereby authorize electronic billing for all of my claims.	Initial Here:
"No Show" Appointment Policy: A "No Show" is when a patient does not show up or does not call to cancel at least 24 hours prior to the scheduled appointment. • All no shows will be documented in the patient's chart and the patient will be notified by letter. • If 3 missed appointments have occurred without proper notice you will be considered for termination from the practice. When you are formally released from the office, the office will provide only emergency care for a period of 30 days.	Initial Here:

Authorization for Review of Prescription Drug History (RX) & Formulary Information: I hereby grant permission for Willamette Valley Clinics, LLC to obtain RX history and RX formulary information from an external source. This information will provide formulary plan preferences and previous prescribed drug information from your prescription plan to aid us with your treatment plan.	Initial Here:
Clinic Communication	
Patient Portal Acknowledgement and Agreement: I have been notified that once I log in to the Willamette Valley Clinics, LLC patient portal, I need to read the Rules and Regulations regarding the Patient Portal. I understand the dangers with online messaging between the clinic and me, and agree to the rules. I also agree to follow the rules displayed on the log in screen. I agree to follow any other instructions that the clinic may give me regarding the use of the portal. I understand messages from me to the clinic will become part of my medical chart. I agree with the information that I have been provided. Please provide email address below: • Email Address: _____	Initial Here:
I grant permission for reminders of upcoming scheduled appointments to be left on my answering machine or with an authorized designated party, and/or sent via email, text message, or post card to your household. Notification regarding the availability of pathology, laboratory, and etc. results may also be left on your answering machine or with a family member who answers the telephone at your residence. Actual results however will not be left on your answering machine, though they may be communicated to those you authorized as a designated party. If you provided a cell phone number in your contact information, we will contact you on your cell phone and, if needed, may leave a message (including, without limitation, email, voicemail and text message). If you choose to receive text messages, applicable carrier charges may apply.	Initial Here:
Prescription (RX) Refills: You will need to call your pharmacy for prescription refills, with the exception of controlled prescriptions (narcotics) that will need a physical prescription. The pharmacy will notify the clinic if additional approval is needed. Please allow 48 business hours for all refills. **We will not refill non-emergency and/or controlled prescriptions on a Friday, weekend, or holidays.**	Initial Here:

Patient notification of received items/acknowledgments and agreements

☐ Received Patient Financial Policy	☐ Offered HIPAA Privacy Notice	☐ Received No-Show Policy

I agree that all information is correct and I have given my consent to treatment and other items by initialing those sections.

Patient, Parent or Guardian's Signature: _____ Date:_____

A copy of this signature is a valid as the original and is in effect until I revoke it. I understand this form will not be updated at each visit but will be completed annually. I will be responsible to provide any demographic/insurance changes at time of visit.

(revised 12/2016)

Willamette
Valley Clinics

SECTION: Financial	**NUMBER**	
TITLE: Financial Policy	**EFFECTIVE DATE**	10/1/2011
	REVISION DATES	
PAGE NUMBER:	**REVIEW DATES**	
REVIEW RESPONSIBILITY: Manager, CBO		

Purpose: To ensure fees and patient out of pocket expenses are collected by WVC, LLC employees when services are rendered.

Non-Insured: Payment is due at the time the service is rendered. Patients are offered a prompt pay discount of 40% for Primary Care and 50% for Specialist services if paid at the time of service.

Patients with balances greater than $500.00 will be expected to make a minimum payment equal or greater than ¼ of the total amount due. The balance should be paid in full within (4) months from the date of service. Failure to comply will result to further collection activity.

Patients with balances less than $500.00 will be expected to make minimum payments equal or greater than 1/3 of the total amount due. The balance should be paid in full within (3) months from the date of service. Failure to comply will result to further collection activity.

Insured Patients: Co-payments, deductibles, and/or Co-Insurance are due at the time of service. If patients provide valid insurance information, WVC, LLC will bill insurance on an assigned basis. Charges not covered by the patient's insurance will be billed to the patient as outlined on the Insurance explanation of benefits.

Cash, Check, and most major credit cards are accepted. A $25.00 fee will be charged to the patient per occurrence for any funds returned by the financial institution for non-payment.

Delinquent accounts will be referred to CBC Collection Agency for further collection efforts. Accounts are considered delinquent if unpaid after 90 days and referred after 150 days of non-payment. In the event a patient account is referred to the collection agency, the patient will be required to pay the outstanding balance in full prior to receiving further treatment. Delinquent accounts that are referred to the collection agency are subject to dismissal.

Billing inquiries should be directed to the WVC, LLC Clinics Business Office.

Patients are to receive, review and sign the Financial Policy (Addendum 1) prior to receiving services.

Patient Financial Policy

Patient Name: _____ Account #_____Date _____

Thank you for choosing Willamette Valley Clinics, a division of Capella Healthcare. We are strongly committed to providing you and your family with the best available medical care.

We are pleased to accept and bill your insurance we contract with, on an assigned basis subject to verification of your coverage. Please understand that your insurance plan is between you and your insurance company; therefore, Willamette Valley Clinics, LLC will not become involved in any disputes you encounter with your coverage or become engaged in litigation with your insurance company. You are fully responsible for any amounts not paid by your insurance.

We accept Cash, Check and most credit cards. You will be charged a $25.00 fee for any payments returned by your financial institution for non-payment.

Non-Insured Patients: Payment is due at the time of service unless previous payment arrangements are made. We offer a 40% prompt pay discount in our primary care clinics and a 30% prompt pay discount in our specialty care clinics when paid in full at the time of service.

Insured Patients: All out of pocket expenses including co-payments, deductibles and/or co-insurance are due at the time of service. It is your responsibility to provide us with your insurance information prior to receiving services. Verification of benefits is not a guarantee of payment and you will be responsible for any services considered non-covered by your insurance. If for any reason your insurance company does not cover services you received within (60) sixty days, the full amount billed will become your responsibility to pay immediately.

Worker's Compensation: If you were injured at work and want us to bill your employer's workers compensation carrier, we may need to get authorization from the carrier in order to treat you. If authorization is not obtained, we may not be able to provide services to you.

Motor Vehicle Accidents: If you were injured as a result of an motor vehicle accident and want us to bill motor vehicle insurance, we require a deposit of ½ of our fees prior to providing services. We will bill your motor vehicle insurance on an assigned basis. In the event we receive full payment from your auto insurance, we will refund the amount you overpaid. You will be responsible for any balances not covered by your auto insurance.

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable out of pocket expenses, are my responsibility.

_____	_____	_____
Date	Patient or Guarantor Signature	Printed Name