orchid health
wade creek clinic

535 NE 6th Ave., Estacada, OR 97023
Office: (503) 630-8550
Fax: (503) 862-5060

Greetings,

Welcome to Orchid Health Wade Creek Clinic! Orchid Health was founded several years ago with the belief that our state's rural communities deserve to have accessible, high quality healthcare that is local, comprehensive, and takes the time to address what matters most to you.

Enclosed are our patient registration forms. Please complete these forms to the best of your knowledge. Included is a **Release of Information** form, which allows us to request your past medical records prior to your first visit. We ask that you **complete this form and mail it back to us** as soon as possible using the prepaid envelope included. This will allow our providers to best prepare for your visit. We are offering a $15 Gift Card Incentive for anyone who returns all of their paperwork, including this Release of Information, in advance, and then attends their first New Patient Appointment at our Clinic. This will enable us to receive Medical Records ahead of time, which will improve our ability to care for you!

Additionally, your previous medical records must be received and reviewed prior to the prescription of any controlled substances. A Controlled Substance Agreement, which allows for random urine drug screening, must be signed before the prescription of controlled substances by Orchid Health providers.

In order for us to best serve you:

1. Please check in at the clinic fifteen minutes prior to your scheduled appointment time.
2. Please bring the **bottles of any current medications** you are taking.
3. Please bring your **insurance card** and your **ID** with you to this visit.
4. If you need to cancel or re-schedule your visit please provide us with 24 hours notice.

We are located at 535 NE 6th Ave. Estacada, OR 97023, to the right of the High School. If you have any questions, please feel free to call (503) 630-8550.

We look forward to meeting you!

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ORCHID WADE CREEK CLINIC REGISTRATION FORM

(Please print)

Name: _____ Gender: Male/Female/Other

First - Middle - Last

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name: _____

Former Name: _____Marital Status: Married/Single/Divorced/Separated/Widowed/Partner

Date of Birth (mm/dd/yy):_____Social Security Number: _____

Home Phone: _____Mobile Phone: _____Work Phone: _____

Email: _____Preferred communication method: _____

Mailing Address: _____ City: _____ State: _____ ZIP Code: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Current Medical Provider/Primary Care:_____

Preferred Language: _____

Optional

Race/Ethnicity: (You can choose more than one if appropriate) ☐ White ☐ Black or African American ☐ Asian

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino ☐ Jewish

☐ Other _____

INSURANCE INFORMATION

(please bring your insurance card to our receptionist)

Please indicate primary insurance type: _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PERSON Financially Responsible for Bills and Payment:

Name: _____ Best Phone Number: _____

Mailing Address: _____ City: _____ State: _____ ZIP Code: _____

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CONSENT FORM

Consent for Treatment: I consent to medical treatment of medical services performed or prescribed by the attending or the consulting medical providers at Orchid Health, and I agree to the performance of treatments or procedures which are considered necessary, routine, or advisable. An example of some treatments performed at Orchid:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Assessment and management of chronic health conditions
- Age appropriate reproductive health
- Routine lab tests and Immunizations
- Health education, counseling, and wellness promotion
- Prescription medications if appropriate
- Mental health services
- Referral for health care services not provided by Wade Creek Clinic

Authorization of Payment: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive. I also authorize release of any medical records necessary to allow the insurance company to pay for these services, within the guidelines of the HIPAA (Privacy) Laws. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If I do not have an active insurance, I agree to pay for services at the time they are received.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice is provided the first time I receive services from Orchid Health and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities, and I agree to abide by these guidelines. This form can be found on our website under patient forms, and is available at the clinic upon check-in.

Consent to Photograph for Electronic Health Records: I authorize Orchid Health to take my photograph to be stored in my electronic health record. This photograph will be used to identify me and help protect me against identity theft.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to local Hospital Networks to Access Health History Information: I authorize the release of my historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Patient or Authorized Representative Name (Please print) _____

If authorized representative please state relationship to patient _____

Patient or Representative Signature _____ Date _____

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B. _____

_____ S.S.# _____

City, State, Zip

Best Contact Phone _____

I Authorize Information Released FROM: (please print)

Name: _____
Address: _____
City, State, Zip:_____

Please Send My Records TO: (fax preferred)

Name: **Orchid Health Wade Creek Clinic**
535 NE 6th Ave. Estacada, OR 97023
Fax #: **(503) 862-5060**

Purpose of Release

❒ Establishing New PCP ❒ Sharing Health Information (from Consultant/Specialist) ❒ Personal Use ❒ Legal

Type of Information To Be Released

❒ **Complete** Medical Records ❒ Include Mental Health Records ❒ Include Confidential Records/HIV or other
❒ Include Records relating to Drug or Alcohol Treatment:_____

❒Other (specify): _____

This authorization will expire one year from the date of the signature below.
I understand that I can change my mind about this authorization at any time by writing to the health care provider or to Orchid Health Wade Creek Clinic, but that any information already transferred will remain in our Confidential Medical Record System.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information if it is relevant for consultation, or if you request we transfer your records to another location.
- I am allowed to receive a copy of this Authorization.

Patient or Authorized Representative Name (Please print) _____
(*If authorized representative please state relationship to patient)*

Patient or Representative Signature _____ Date _____

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COMMUNICATION PREFERENCES

Patient Name (last, first, middle): _____ Date of Birth:_____

Personal Communication Methods:
As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care.

❑ I give permission to **leave medical information** pertaining to me at the contact information marked **Yes** below:

Communication Type	Number	Ok to leave information?	Ok to text?
Home Phone			
Cell Phone			
Other _____			

❑ **I would like to sign up to communicate ONLINE through the PATIENT PORTAL**.

My email address is:_____

Authorization to Disclose Information to Others:
Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

I give permission to release the following information to the individuals listed below:

- ❑ All health information about me created or received by Orchid Health Wade Creek Clinic, including medical records, case or medical management, billing, payment, claims and enrollment.
- ❑ Sensitive information including: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

TERM: This authorization will remain in effect for a period of **one year**. I can revoke this authorization in writing (at any time) as described in the Orchid Health Wade Creek Clinic Notice of Privacy Practices.

_____ _____
Signature Date

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Patient Rights & Responsibilities

Our goal is to provide the highest quality of care for our patients. We respect and value you, and have created this document to help you understand what to expect from us, and what we expect from you.

You Have the Right To:

- Exercise these rights without regard to sex, age, economic status, educational background, race, color, religion, national origin, sexual orientation, gender identity, marital status, or the source of payment for care.
- Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand.
- Have privacy during care discussion, counseling & treatment.
- Personally review your medical records in the presence of a health care professional.
- Know the name and qualifications of staff providing your care.
- Know your diagnosis, health problems, test results, the potential advantages and risks of treatment, procedures, and medications in language you can understand.
- Expect that all services, treatment and counseling techniques will take place with your informed consent.
- File a complaint regarding any aspect of Orchid Health. Those who file complaints will be free from retribution.
- Have another individual present in the exam room with you, if you so desire.
- Request that another Orchid provider administer your care.
- Be treated from a culturally appropriate perspective.
- Receive quality medical care from a qualified provider.

You Have the Responsibility To:

- Treat Orchid staff with consideration, respect and dignity. Threats to any staff member will result in immediate termination of your care.
- Understand that your lifestyle does affect your health and take an active part in your health care.
- Follow the agreed upon treatment plan. If you choose not to follow or are unable to follow the treatment plan, it is your responsibility to inform your medical provider.
- Provide accurate and complete personal contact and insurance information as well as information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your health care.
- Communicate with your provider so that you understand a medical course of action and what is expected of you during the course of treatment.
- Observe Policies and Procedures that are for the safety and consideration of all patients and staff such as:
    - Request Prescription (Rx) refills in a timely manner. Contact your pharmacy, mail order pharmacy, or our office no less than 72 hours before your Rx is due to be filled.
    - Schedule appointments for CONTROLLED Prescriptions one week in advance
    - Arrive 15 minutes prior to your scheduled appointment time.
    - Call to cancel/ reschedule your appointments 24 hours in advance if needed.
    - Have proof of insurance and if applicable, your copayment, at the time of your appointment.