orchidhealth
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ORCHID HEALTH REGISTRATION FORM

(Please print)

Name: ____ Today's Date: ____________ 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: _____________________

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 or Spanish

Origin ☐ 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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MINOR CONSENT FORM

Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age except for family planning, sexually transmitted disease services, and certain mental health services. ORS 109.610, ORS 109.640, ORS 109.675.

I understand the following types of services are offered through Orchid Health:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Management of Chronic Health Conditions
- Age appropriate reproductive health
- Routine lab tests, Immunizations
- Prescription medications
- Mental health services
- Referral for health care services not provided by Orchid Health

I have read and fully understand the above information, have asked questions about anything not clear to me. I understand that I may revoke this consent at any time.

I (parent/legal guardian) ____________________________ give permission for my child, _________________________, to receive medical care at Orchid Health.

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. These can be found on our website under patient forms, and is available at the clinic upon check-in.

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.

Consent to Call and Text I consent to receive calls and/or texts from Orchid Health for my protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Authorization of Payment:
Parent or Guardian: I __________________________________assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and also authorize release of any medical records necessary to facilitate my treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. 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.

Parent/Guardian Signature ___________________________________ Date _____________

Relationship to Minor: ___________________________________

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MEDICAL RECORDS RELEASE

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)

Clinic/Doctor's Name: ________________________
Address: ____________________________________
City, State, Zip:______________________________

Please Send My Records TO: (fax preferred)

Orchid Health Wade Creek
535 NE 6th Ave.
Estacada, OR 97023
Fax: (503) 630-8551
Phone: (503) 630-8550

Orchid Health Oakridge
47815 Highway 58
Oakridge, OR 97463
Fax: (541) 782-5823
Phone: (541) 782-8304

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, 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.

Parent/Guardian Signature ____________________________________ Date ______________

Relationship to Minor: ____________________________________

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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 outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

OK to leave medical information on home phone: YES NO

OK to leave medical information on mobile phone: YES NO

❑ **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, including medical records, case or medical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.
- ❑ All health information **except for**: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

Permission for non-guardian to consent for child's medical treatment (if patient is under 15 y/o):

- ❑ I give permission for the above listed individuals to provide consent for treatment on my behalf and to accompany my child/dependant to their medical appointments.

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 Notice of Privacy Practices.

Parent/Guardian Signature ___________________________________ Date _____________

Relationship to Minor: ___________________________________