Name:______________________________ La Pine CHC Pediatric Date
Date of Birth:______________ Initial History Documentation

HOME ENVIRONMENT *(circle where appropriate)* PLEASE **USE BLUE OR BLACK INK**

Who lives with child/adolescent?

Mother's name: (Biological / Step / Adoptive / Foster) Lives with child: YES / NO

Father's name: (Biological / Step / Adoptive / Foster) Lives with child: YES / NO

Other *(name & relationship):*

Siblings *(at home, first names and age/s):*

What type of residence: Single family / Multi-family / Trailer / Temporary Was it built before 1978?: YES / NO

Tobacco users/smokers at home: YES / NO

Is anyone a regular user of alcohol/drugs at home: YES / NO

Guns/firearms in the home: YES / NO

Is anyone being hit/hurt or touched in a bad way at home?: YES / NO

Do you have enough money for food? YES NO Do you have transportation to get to your appointments? YES NO
Do you have enough money for housing? YES NO Do you have enough money for utilities? YES NO

Is there anyone in the household with mental illness? YES NO
If YES are they being medically treated for the mental illness? YES NO

MEDICINES & ALLERGIES

Medication/s taken regularly	Allergies: YES / NONE
	To Medications:
	To Foods/other (bees, latex):
	Was allergy testing done: YES / NO

IMMUNIZATIONS

Do you believe you/your child is completely up-to-date on recommended immunizations?: YES / NOT SURE

Do you have an up-to-date copy of immunizations?: YES / NO

Any reactions or problems?: YES / NO (if yes, please describe)

PAST MEDICAL HISTORY

Birth: Full term (>37 weeks) / Early / Late *(circle)* Pregnancy lasted ____ weeks *(normal is 40)*
Birth Weight:______pounds ______ounces

Pregnancy complications:

Tobacco / Alcohol / Drug *(circle)* use in pregnancy:

Birth complications:

Hospital stay lasted: 1-3 days & routine / prolonged > 3 days due to:

Hearing screen passed: YES / NO

Hospitalizations (list with date/s):

Surgeries (list with date/s):

Chronic illness/es:

Developmental *(including speech)* **problems/delays**:

Psychiatric care / hospitalization/s:

Reviewed by ____________________ Date_______________

FAMILY HISTORY

Please circle & indicate affected, blood relative/s: Mother, Father, Brother/s, Sister/s, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, Aunts/Uncles/Cousins (indicate maternal/paternal)

Y	**N**	Diabetes:
Y	**N**	High blood pressure:
Y	**N**	High cholesterol:
Y	**N**	Heart disease:
Y	**N**	Asthma:
Y	**N**	Allergic rhinitis/Hay fever:
Y	**N**	Thyroid disease:
Y	**N**	Gastrointestinal: (Crohn's, Ulcerative colitis / Irritable bowel / Constipation)
Y	**N**	Hepatitis:
Y	**N**	Skin problems: (Eczema / Psoriasis)
Y	**N**	Abnormal Bleeding or Blood clotting:
Y	**N**	Mental health: (Depression / Anxiety / Bipolar / Schizophrenia)
Y	**N**	Kidney disease: (Stones / Infections / Kidney failure)
Y	**N**	Substance or alcohol abuse:
Y	**N**	Learning problems or disability: (ADHD / speech/language delay / dyslexia)
		Other:

REVIEW OF SYSTEMS *(check if currently present)*

	Fever or chills		Abnormal heart beat		Joint stiffness or swelling
	Loss of appetite		Passing out		Limp
	Weight gain or loss *(circle which)*		Spitting up frequently		Abnormal gait or stance
	Fatigue		Nausea		Pain in arms or legs
	Trouble sleeping		Vomiting		Worrisome or changing moles
	Depressed feelings		Abdominal pain		Hives
	Anxious feelings		Diarrhea		Rash
	Thoughts of death / suicide *(circle)*		Constipation or irregularity		Blot clots
	Abnormal gaze or eye movements		Heartburn		Easy bruising or bleeding
	Vision loss or disturbance		Painful or difficult swallowing		Swollen lymph nodes
	Eye pain or redness		Blood in the stool		Headache
	Frequent nosebleeds		Pain or burning with urination		Weakness
	Ear pain		Frequent urination		Numbness
	Hearing loss		Blood in urine		Abnormal sensations
	Hoarseness		Incontinence		Females: Painful periods
	Snoring nightly		Excessive urination		Females: Heavy periods
	Shortness of breath		Excessive thirst		Females: Irregular periods
	Cough		Excessive hunger		Females: Vaginal discharge
	Wheezing		Intolerance to cold / heat *(circle)*		Males: Discharge from penis
	Labored breathing		Excessive sweating		Males: Pain in testicle/s
	Chest pain		Trouble or pain in teeth or mouth		Males: Swelling or lump in testicle/s

Adolescent Health *(please answer by circling if you are **12 and older**)*

Have you ever had sex (includes oral sex)?: YES / NO Have you ever been forced to have sex?: YES / NO

Have you used cigarettes or chewing tobacco?: YES / IN THE PAST / NEVER

Have you used alcohol?: YES / IN THE PAST / NEVER

Have you taken pain pills, marijuana or other substances to get high?: YES / IN THE PAST / NEVER

Do you feel you have been depressed or very worried or anxious? : YES / IN THE PAST / NEVER

La Pine Community Health Center - Patient Information Data Sheet

Patient's Name: ____ Date: _____________________
(LAST, FIRST, MIDDLE INITIAL)

Date of Birth: _____________________ Patient's SSN: ________________________________

Please complete this section only if you are 15 years old or older.

What sex were you when you were born? [ ] Male [ ] Female [ ] Unknown

What gender do you identify yourself as?
[ ] Male [ ] Female [ ] Transgender Male to Female [ ] Transgender Female to Male [ ] Other

What is Your Sexual Orientation?
[ ] Straight [ ] Lesbian/Gay [ ] Bisexual [ ] Something Else [ ] Don't Know [ ] Choose Not To Disclose
Other Sexual Orientation: ____

Do you have a preferred Pronoun? (Circle one)
he/him she/her they/them ze/zim Decline to answer Unknown

Marital Status: [ ] Child [ ] Single [ ] Married – Spouse's Name: _______________________________

[ ] Divorced [ ] Widowed [ ] Legal Domestic Partnership

Do you require an interpreter? [ ] Y [ ] N If Yes, which type? ____

Home Phone: __________ OK to Contact [ ] Y [ ]N Work Phone: _________ OK to Contact [ ] Y [ ] N

Cell Phone: ____________ Ok to Contact [ ] Y [ ] N

Mailing Address: ____ OK to Contact [ ] Y [ ] N
(P O Box or Street Address) (City) (State) (Zip Code)

Physical Address: ____
(P O Box or Street Address) (City) (State) (Zip Code)

Emergency Contact: _______________________ Phone #: _________________ Relationship: ________________

Additional Contact: _______________________ Phone #: _________________ Relationship: _______________

RESPONSIBLE PARTY INFORMATION

Name: ____ Phone: ___________________

Date of Birth: ______________ Sex: M or F (Please Circle) SSN #: ___________________

Mailing Address: ____
(P O Box or Street Address) (City) (State) (Zip Code)

Physical Address: ____
(P O Box or Street Address) (City) (State) (Zip Code)

Relationship to Patient: ____

Patient Insurance Information

PLEASE SIGN BELOW EVEN IF YOU DO NOT HAVE INSURANCE

Patient's Name: ____

Insurance Company

(Primary): ________________________ ID#:____________________ Group #:_______________

Policyholder's Name: ______________________ DOB:____________ Sex: M or F (Please Circle)

Relationship to Patient: _______________________ SSN:__________________________________

Insurance Company

(Secondary): ________________________ ID#:____________________ Group #:_______________

Policyholder's Name: ______________________ DOB:____________ Sex: M or F (Please Circle)

Relationship to Patient: _______________________ SSN:__________________________________

Financial Agreement and Authorization for Assignment of Benefits

The providers and Staff of La Pine Community Health Center have your healthcare as our first priority. After we provide healthcare services to you, we will bill your insurance for you. We understand that at times insurance billings can seem complicated and we have billing staff available to help you with any questions you may have.

We will bill all insurance companies, but we have no control over the dollar amount a non-participating company will pay for your services. Payment has been set by these companies without our input and as a result, you, the patient can possibly be left with an account balance higher than expected.

It is important that you check with your insurance before you receive any medical services so that you are aware of what your possible financial responsibility for that service may be. We can provide you with any information you may need to verify with your insurance company.

I accept full responsibility for payment and I hereby assign to La Pine Community Health Center any and all insurance benefits due me to the full extent of my financial obligation to said provider. In the event of non-payment I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required.

It is agreed that payments will not be delayed or withheld because of any insurance coverage and all proceeds of insurance are assigned and/or payable to this office where applicable. (A copy of this assignment is as valid as the original)

Agreement: I hereby authorize the release of pertinent medical records to my insurance carrier(s).

I have read and understand the above information on: Date: ________________________________

Signature: ______________________________________ Printed Name: _________________________

Financial Policy

PAYMENT FOR SERVICES:

We will bill participating insurance companies as a courtesy to you and will assist with your benefits. If we have not received payment from your insurance company within 60 days of the date of service, you will be expected to pay the balance in full. Insurance is a contract between you and your insurance carrier. Payment for services provided to you is ultimately your responsibility.

Payment is required at the time services are rendered **unless other arrangements have been made in advance.** This includes applicable coinsurance, deductibles and co-payments for participating insurance companies. There will be 25% discount for private pay individuals who pay in full at the time of service. La Pine Community Health Center accepts cash, personal checks, debit and credit cards. A service charge will be added for returned checks.

PAST DUE ACCOUNTS:

Patients with an outstanding balance must make arrangements for payment. We realize that people may have financial difficulties at times. Therefore, we have implemented a payment plan for those who cannot pay in full at the time of service.

On accounts where a payment arrangement has been made, payment is due by the date agreed upon. Patient balances greater than 90 days old or those failing to honor agreed upon payment terms may be turned over to our collection agency. Any patient turned over to collections may be discharged from our practice. Please contact us to apply for our sliding fee scale program or for assistance with applying for Oregon Health Plan (OHP).

CANCELLATIONS/MISSED APPOINTMENTS:

If you are unable to keep your appointment, please call us as soon as possible; appointments cancelled less than 24 hours are considered a NO SHOW. We realize emergencies come up and your plans may change. Giving us as much notice as possible (at least 24 hours) helps us to better serve you and our other patients. If you fail to keep your appointments with us for a total of 3 times, you may be discharged from our practice.

ASSISTANCE *or* QUESTIONS:

If you need assistance or have questions regarding billing issues or the Financial Policy, please contact the billing office between: **8:00 a.m. and 5:00 p.m. Monday through Friday at 541-536-3435**

I have read and understand La Pine Community Health Center's Financial Policy I agree to assign insurance benefits to La Pine Community Health Center whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the agency for costs of collections, including attorney fees.

______________________________ ______________________ ______________

Signature of Patient/Legal Representative   Printed Name   Date

CONSENT TO TREATMENT:

I agree to get medical treatment from La Pine Community Health Center staff as my health care providers see fit. I understand that services might be tests to see what's wrong, exams and treatment. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at the La Pine Community Health Center. I may cancel this consent in writing.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Your protected health information is made up of your health condition(s) and treatment at the La Pine Community Health Center which includes lab test results, medical history, treatment progress or any other related information. By signing this form, you agree that the La Pine Community Health Center may use and release protected health information about you. It can be used for treatment and payment. It can also be used for health care operations and in other ways allowed by law. Our notice of privacy practices gives information about how the La Pine Community Health Center and its staff may use and release protected health information about you.

PCPCH PARTICIPATION AND ENROLLMENT:

I understand that La Pine Community Health Center is recognized as a Tier 3 Patient Centered Primary Care Home (PCPCH), certified through the Oregon Health Authority. My signature on this form indicates that I have received and read the PCPCH program outline and I agree to partner with La Pine Community Health Center and its providers to participate in their Patient Centered Medical Care Home program. I have received information on Patient Centered Primary Care Homes and will fulfill my role as a medical home patient.

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS:

I have been offered a copy of La Pine Community Health Center's Notice of Privacy Practices and Patient Rights and have had a chance to ask questions about how my information may be used or disclosed.

By signing this form I acknowledge that I have received or been offered the above stated items.

______________________________ ______________________________

Print Patient Name Date of Birth

______________________________ ______________________________

Signature (Patient/Parent/Guardian) Date

La Pine Community Health Center
Disclosure of Protected Health Information (PHI)
(HIPAA Form)

Patient Name: ________________________________ DOB: ____________________

La Pine Community Health Center values the privacy of its patients and is committed to operating its practice in a manner that promotes patient confidentiality while providing high quality patient care.

At times, La Pine Community Health Center has a need to reach you for reasons related to care (for example, to discuss lab results or medication).

☐ I give my permission to La Pine Community Health Center to give protected health information to the following people in person, on the phone, and/or by leaving a voice mail message: (for example: lab or x-ray results, test results, medication information)

Name:_________________________ Relationship:____________________ Phone #_______________

Name:_________________________ Relationship:____________________ Phone #_______________

Name:_________________________ Relationship:____________________ Phone #_______________

Name:_________________________ Relationship:____________________ Phone #_______________

Names appearing above- do not need to be added below

☐ I give my permission to leave messages **(without giving protected health information)** with the person answering the phone or on voicemail at the following numbers:

Location or name: __________________________________ Phone #___________________________

Location or name: __________________________________ Phone #___________________________

Location or name: __________________________________ Phone #___________________________

Signature ____

(Patient/Parent/Guardian Signature if patient is under the age of 15)

Print Name____ Date____________________

La Pine Community Health Center

Temporary Assignment of Consent, For the Treatment of a Child

I (we)____
Name(s) and address(es) of parent(s)/legal guardian(s)

designate to ____
Name and address of designee

the power to consent in our absence to medical care for our child.

______________________________________ ________________________
Name of child DOB of Child

Parent's/gurdian's phone number: ______________________________________

Dates of expected absence: from ____________ to ____________

Child's Primary physician: ______________________________________

Physician's address and phone number: ____________________________

____

Child's Medical insurance company: ________________________________

Child's Policy #: ____

CHILD'S MEDICAL HISTORY

Chronic conditions____

Medications that need to be given on a regular basis:

____
Medication name, dosage, frequency

Allergies:____

Dietary or other restrictions: ____

_________________________ __________ (this consent is valid for 1 year from this date)
Signature of parent/guardian Date