COLUMBIA GORGE
FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

CGFM Financial Policies

Date: _____ (mm/dd/yyyy) **Birthdate:** _____ (mm/dd/yyyy)

Patient Name: _____ (last name, first name, middle initial)

Thank you for choosing Columbia Gorge Family Medicine (CGFM) for your healthcare services.

Please review the policies below carefully and feel free to ask questions should you have them. In order to ensure accurate billing and to prevent fraud, we ask each patient to provide us a copy of a photo ID along with their insurance card. When you receive a new insurance card or change to another health plan, it is your responsibility to inform us with updated policy info and provide us with a copy of the card
.
We bill your insurance as a courtesy and must have accurate health plan information. This includes primary and secondary, automobile and workers' compensation insurances. Failure to provide us with accurate and up-to-date information specific to your visit will result in patient responsibility for the balance owed.

It is the patient's responsibility to check with their health plan for eligibility and benefit details including: 1) In-network provider status; 2) Primary Care Provider (PCP) assignment; and 3) potential financial responsibility for services not covered on or after the date of service at CGFM. **By signing below, I accept this responsibility.**

Most office visits require a co-pay which is due at the time of service. If your co-pay is not printed on your card and/or we are unable to confirm when checking eligibility, a standard deposit of $25 will apply.

If you don't have health insurance, have a high deductible plan or your account is in collection status, we require a $75.00 deposit every visit. Your $75 deposit will be applied to your total out of pocket.

For visits during extended hours (Acute Care) we collect $100 at the time of service if uninsured. We will bill your insurance and if payment is made we will refund any monies owed to you. If you are an established patient we will collect based on your insurance plan's estimated patient responsibility, otherwise a $50 deposit will be collected.

Patients without health insurance (self-pay) will receive a 10% "uninsured discount". The uninsured discount is applicable to professional services only and doesn't apply to drugs, vaccines, or medical supplies. The uninsured discount will only apply to services when Patient was truly uninsured and will be reversed if we discover active health insurance or a health plan retroactively covers patient visit.

Please inquire with our billing staff about 10% pay in full discount or payment plan options.

There is a $30 charge on returned checks. Failure to pay your bill or make arrangements with our billing department could result in dismissal from the practice and your account being assigned to an outside collection agency where you will be responsible for all collection cost and attorney fees incurred.

Missing your appointment without calling us to cancel or reschedule prior to 24 hours will result in a $25 fee. After three (3) no-shows, your account will go to review for dismissal.

I understand and agree to Columbia Gorge Family Medicine's financial policies as described above.

Signed _____ (mm/dd/yyyy) **by** _____ Signature of patient

Signed _____ (mm/dd/yyyy) **by** _____ Signature of parent, guardian, or legal representative

Patient Demographics

COLUMBIA GORGE FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____
(mm/dd/yyyy)

Patient Name: _____
(last name, first name middle initial)

Birthdate: _____
(mm/dd/yyyy)

Sex: ◯ Female ◯ Male

Previous Name: _____
(e.g., maiden name)

Preferred Name: _____
(e.g., nickname)

Home Address

_____
Address

_____
Mailing Address

_____ _____
City, State Zipcode

Patient Contact Information

Home phone: _____
Work phone: _____
Cell phone: _____
(Please include area code)

Marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Secure Web Portal Access

If you would you like to have access to our portal, please check in at the front desk for your log-in and password.

Emergency Contact Information

Name: _____
(last name, first name middle initial)

Relationship: _____

Home phone: _____
Work phone: _____
Cell phone: _____
(Please include area code)

Other Contact Information

Name: _____
(last name, first name middle initial)

Relationship: _____

Home phone: _____
Work phone: _____
Cell phone: _____
(Please include area code)

Detailed Voicemail Message Consent

Can Columbia Gorge Family Medicine leave detailed messages about your appointments, lab results, or conditions on your Phone Voicemail to avoid multiple call attempts? ◯ YES ◯ NO

Race

◯ American Indian or Alaska Native
◯ Asian
◯ Native Hawaiian
◯ Black or African American
◯ White
☐ Hispanic
☐ Other

Ethnicity

◯ Hispanic
◯ Non-Hispanic

Preferred Language

◯ English
◯ Spanish
Other: _____

Check here if you to decline to answer: ☐

Insurance Information

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____
(mm/dd/yyyy)

Name: _____
(last name, first name middle initial)

Primary insurance carrier :

_____
Primary insurance name

_____
Address

_____
Address

_____ _____
City, State Zipcode

_____
Phone number

Subscriber information:

_____
Subscriber name (last name, first name middle initial)

_____
Subscriber date of birth (mm/dd/yyyy)

Subscriber number: _____

Group Number: _____

Secondary insurance carrier :

_____
Primary insurance name

_____
Address

_____
Address

_____ _____
City, State Zipcode

_____
Phone number

Subscriber information:

_____
Subscriber name (last name, first name middle initial)

_____
Subscriber date of birth (mm/dd/yyyy)

Subscriber number: _____

Group Number: _____

Consent for Treatment

IMPORTANT: To be filled out by patient if 14 years or older

COLUMBIA GORGE FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____ **Birthdate:** _____
(mm/dd/yyyy) (mm/dd/yyyy)

Patient Name: _____
(last name, first name, middle initial)

CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians. This consent is valid until such time it is revoked in writing or a new consent is completed.

RELEASE OF INFORMATION:

By signing this form, you are granting consent to Columbia Gorge Family Medicine to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices is available at the front desk and also our website, www.cgfm.com. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 541-386-5070. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request and we are bound by this agreement.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

ASSIGNMENT OF BENEFITS:

I hereby authorize my insurance benefits be paid directly to Columbia Gorge Family Medicine. I understand I am financially responsible for non-covered services, any remaining deductible and co-pay. I also authorize Columbia Gorge Family Medicine to release any information required in the processing of this claim.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent. The date effective of a written revoked consent will be the date it is received and scanned into the patients chart.

PRESCRIPTION DATA:

I authorize Columbia Gorge Family Medicine to obtain information regarding my prescriptions from pharmacies and other outside sources to better coordinate my healthcare. ☐ Yes ☐ No

REVOCATION RIGHTS:

I hereby consent to the authorizations described above and will accept medical treatment from Columbia Gorge Family Medicine. This authorization will stay in effect until such time a new one is signed or a written revocation is done.

Signed _____ **by** _____
(mm/dd/yyyy) Signature of patient

Signed _____ **by** _____
(mm/dd/yyyy) Signature of parent, guardian, or legal representative

Parent / Guardian / Representative Name (Printed): _____

Any person listed below has my permission to authorize medical treatment for me/this patient. These same people have the right to discuss my health care with representatives of the practice for purposes of treatment, billing, or health care operations.

1) Name: _____
Please PRINT name and relationship to patient Phone Number

2) Name: _____
Please PRINT name and relationship to patient Phone Number

3) Name: _____
Please PRINT name and relationship to patient Phone Number

Adolescent/Teen Health Screening Form

Date: _____ (mm/dd/yyyy) **Birthdate:** _____ (mm/dd/yyyy)

Name: _____
(last name, first name, middle initial)

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

General Health

What do you do for exercise? _____

Are you happy with your physical appearance and the shape of your body? ☐ No ☐ Yes

Have you tried to lose weight or control your weight? ☐ No ☐ Yes

School and Work

If you are in school, what grade are you in? _____

Do you like school? ☐ No ☐ Yes

Do you have any concerns about your performance in school? ☐ No ☐ Yes

Do you work? ☐ No ☐ Yes

If so, what do you do? _____

About how many hours do you work each week? _____

Sexual Health

Have you EVER been sexually active? ☐ No ☐ Yes

If yes, 1. Do you plan to become pregnant this year? ☐ No ☐ Yes

2. What are you using to prevent pregnancy (check one)?

☐ Nothing

☐ Withdrawal ☐ Condoms/film ☐ Spermacide ☐ Implant ☐ IUD

☐ Birthcontrol Pills ☐ Patch ☐ Depo-Provera ☐ Nuva ring ☐ Emergency pill

Have you ever had a sexually transmitted disease, for example, Chlamydia, Herpes, Gonorrhea, or genital warts? ☐ No ☐ Yes

Tobacco Use

Do you currently smoke tobacco cigarettes or cigars? ☐ No ☐ Yes

If so, how much tobacco per week do you consume? _____

Do you use any other tobacco products (chew, e-cigarettes, hookah, etc? ☐ No ☐ Yes

Personal Habits

During the **past 12 months**, did you:

1. Drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or religious events. ☐ No ☐ Yes

2. Smoke any marijuana or hashish? ☐ No ☐ Yes

3. Use anything else to get high? (Anything else includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff." ☐ No ☐ Yes

Feelings

PHQ2 (2015)

Over the past 2 weeks, how often have You been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐

Adolescent/Teen Review of Systems

COLUMBIA GORGE FAMILY MEDICINE

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____ (mm/dd/yyyy) **Birthdate:** _____ (mm/dd/yyyy)

Patient Name: _____ (last name, first name, middle initial)

Check ANY symptoms you've experienced in the last 6 months.:

Last Dental exam: _____ Last Vision exam: _____

General symptoms	None	Fever	Night sweats	Weight loss	Weight gain	Increased fatigue	
Head & Eyes	None	Eye pain	Headache	Loss of vision	Need glasses/ contacts		
Ear, Nose, & Throat	None	Ear pain	Allergies	Sinusitis	Hearing loss	Snoring	Daytime sleepiness
Cardio-vascular	None	Chest pain	Shortness of breath	Racing or irregular heartbeat	Difficulty breathing with exertion	Swelling of calves/ankles	Calf pain while walking
Respiratory	None	Cough	Coughing up blood	Increased phlegm	Shortness of breath	Wheezing	Asthma
Gastro-intestinal	None	Abdominal pain	Blood in stool or black stool	Loss of stool	Diarrhea or constipation	Nausea, vomiting, or indigestion	Trouble swallowing
Urinary	None	Blood in urine	Loss of urine	Pain with urination	Increased urination	Urinating at night	
Male only	None	Pain or lump in testes	Changes in urinary stream				
Female only	None	Abnormal or painful periods	Painful intercourse	Chronic pelvic pain	Abnormal vaginal discharge	PMS	**Last period:** _____
Musculo-skeletal	None	Muscle weakness	Muscle or joint pain	Morning stiffness	Severe joint pain		
Skin	None	Rash	Non-healing sores	Dry skin	Changes in moles	Acne	
Breast	None	Breast discharge	Breast pain	Breast lump			
Neurologic	None	Fainting	Seizures	Numbness	Dizziness	Tremors	Falls
		Weakness	Trouble walking	Headache	Severe memory problems	Difficulty concentrating	
Psychiatric	None	Depression	Poor sleep	Severe anxiety	High stress	Attending counseling	Victim of partner violence
Endocrine	None	Diabetes	Hypothyroid	Hyperthyroid	Hot flashes	Hair loss	Heat or cold intolerance
Hematologic Lymphatic	None	Easy bruising	Swollen lymph glands	Easy bleeding			

PLEASE FILL OUT BOTH SIDES

Medical History

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

Date: _____ (mm/dd/yyyy) **Birthdate:** _____ (mm/dd/yyyy)

Patient Name: _____ (last name, first name, middle initial)

Medical Problems

1. _____
2. _____
3. _____
4. _____

Hospitalizations Why were you hospitalized? When? Where?

1. _____
2. _____
3. _____
4. _____

List all medications you are currently taking and how often you take them.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Do you have any allergies? ☐ No ☐ Yes _____ (Please list any allergies)

Please list family members, their relation to you, and anyone else living with you.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Patient Social History:

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Quit ☐ Yes How much? _____

Use of tobacco: ☐ Never ☐ Quit ☐ Yes How much? _____

Use of street drugs: ☐ Never ☐ Quit ☐ Yes What kind and how often? _____

Is there anything about your living situation that we should know? _____

Family History Does your family have a history of Cancer, Diabetes, Heart disease, Glaucoma, Melanoma, or other major medical problem?

Mother: _____ Father: _____ Sibling 1: _____

Maternal Grandmother: _____ Paternal Grandmother: _____ Sibling 2: _____

Maternal Grandfather: _____ Paternal Grandfather: _____ Sibling 3: _____

Other family medical history: _____ Sibling 4: _____

Adult Women's Health (For female patients only)

Last menstrual period: _____ Number of pregnancies: _____ Date of last Pap: _____

First menstrual period: _____ Number of live births: _____ History of abnormal Pap? _____

Current birth control: _____ Complications: _____ Date of last mammogram: _____