CGFM Financial Policies

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)

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 ________________ **by** ____
(mm/dd/yyyy) Signature of patient

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

Patient Demographics

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(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 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

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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
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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

Medicare Wellness Checkup

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

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

1. During the past four weeks, how would you rate your health in general?

   Good
   Fair
   Poor

2. Do you exercise for about 20 minutes three or more days a week?

   Yes, most of the time
   Yes, some of the time
   No, I usually do not exercise this much

3. How often do you have trouble taking medicines the way you have been told to take them?

   I do not have to take medicine
   I always take them as prescribed
   Sometimes I take them as prescribed
   I seldom take them as prescribed

4. Are you having difficulties driving your car?

   Yes, often
   Sometimes
   No
   I do not use a car.

5. Do you always fasten your seat belt when you are in a car?

   Yes, usually
   Yes, sometimes
   No

6. How far can you walk without stopping to rest?

   I can't walk without help
   Less than 100 feet
   1 block
   Unlimited
   other ________________________________

Please complete both sides

7. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis or drive your own car?) yes no

8. Can you go shopping for groceries or clothes without someone's help? yes no

9. Can you prepare your own meals? yes no

10. Can you meet your personal care needs such as eating, bathing, dressing, or getting around the house without help? yes no

11. Can you handle your own money without help? yes no

12. How often during the past four weeks have you been bothered by any of the following problems?:

	Always	Often	Sometimes	Seldom	Never
Falling or unsteady when standing					
Sexual problems					
Memory problems					
Trouble hearing					
Problems with teeth or dentures					
Problems using the telephone					
Tiredness or fatigue					

13. Does your family have concerns about your memory or ability to think? yes no

List other medical professionals you have seen in the past 12 months.

____

____

____

____

____

Please complete both sides

(65+) Adult Health Screening Form

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Birthdate: ________________ (mm/dd/yyyy)

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

NOTE: We request that you update this form at least once per year. If you have already done so, check here: ☐

Access to Food

In the last 12 months, did you and the people you live with worry that you would run out of food before you were able to get more? ☐ No ☐ Yes

In the last 12 months, did you and the people you live with run out of food before you were able to get more? ☐ No ☐ Yes

Tobacco Use

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

If so, how much tobacco do you smoke per week? ____________________

Do you use any other tobacco products including chew or e-cigarettes? ☐ No ☐ Yes

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

Alcohol Consumption

MEN: How many times in the past year have you had 5 or more drinks in a day? ☐ None ☐ 1 or more

WOMEN: How many times in the past year have you had 4 or more drinks in a day? ☐ None ☐ 1 or more

Alcohol: One drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor (one shot)

Recreational Drugs

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? ☐ None ☐ 1 or more

Note: Recreational drugs include methamphetamines (speed, crystal), cannibis (marijuana), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Mood

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	☐	☐	☐	☐

Caffeine Use

Do you consume caffeine in coffee, tea, energy drinks, etc.? ☐ No ☐ Yes

If so, how much caffeine do you consume in a typical day? ____________________

Adult Review of Systems

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

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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	
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	Incomplete emptying
Male only	None	Erectile dysfunction	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		
Breast	None	Breast discharge	Breast pain	Breast lump			
Neurologic	None	Fainting	Seizures	Numbness	Dizziness	Tremors	Falls
		Weakness	Trouble walking	Headache	Severe memory problems		
Psychiatric	None	Depression	Crying	Poor sleep	Severe anxiety	High stress	
Endocrine	None	Diabetes	Hypothyroid	Hyperthyroid	Hot flashes	Hair loss	Heat or cold intolerance
Hematologic Lymphatic	None	Easy bruising	Swollen lymph glands	Easy bleeding			

Medical History

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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: ____________