ACESO MEDICAL CLINIC

375 Park Ave. Suite 5, Coos Bay, OR 97420
Phone: (541) 808-3066 - Fax: (541) 808-3280

☐ New Patient
☐ Update Information
☐ Address Change
☐ Name Change

PATIENT INFORMATION

Completion of this form in its entirety is required before the time of visit/treatment.

Patient Name: _____ **Preferred Name:** _____
Last First Middle
Other Names Used (Birth, Maiden, or Legal Name Change) _____

Race: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____ **Preferred Language:** _____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Other: _____ **Social Security #** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Address (If Different) _____ **Email Address:** _____

Home Phone Number: _____ **Cell Phone Number:** _____ **Okay to Leave Message? YES or NO**

Employer: _____ **Employer Phone Number:** _____

Spouse/Significant Other (If Applicable): _____ **Date of Birth:** _____

Phone Number: _____ **Employer:** _____ **Social Security #** _____

☐ **CHECK BOX IF SELF**

Responsible Party Name: _____ **Date of Birth:** _____

Relationship to Patient: _____ **Phone:** _____ **Social Security #** _____

Employer: _____ **Employer Phone Number:** _____

EMERGENCY CONTACTS

Contact Name:_____ **Relationship:**_____ **Phone Number:**_____
Contact Name:_____ **Relationship:**_____ **Phone Number:**_____

A copy of your Insurance Card (front & back) is required to bill your insurance.

Patient Primary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

Subscriber Name: _____ **Subscriber DOB:** _____ **Relationship:** _____

Patient Secondary Insurance: _____ **Policy Number:** _____ **Group Number:** _____

Subscriber Name: _____ **Subscriber DOB:** _____ **Relationship:** _____

I acknowledge that I am financially responsible for all charges, whether or not they are covered by insurance for this and subsequent visits. I will be responsible for any and all collection agency fees up to 50% of the amount placed with the collection agency. In the event legal action is sought for collection of my accounts, I will also be responsible for any and all fees associated with court costs, garnishment, and/or attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Patient Signature: _____ **Date:** _____

Parent or Legal Guardian Signature: _____ **Date:** _____

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Patient Name: _____

The following disclosures are made in compliance with the Federal Truth in Lending Law.

The Aceso Medical Clinic, LLC will extend credit to a patient with the understanding that:

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

I hereby authorize The Providers of Aceso Medical Clinic, LLC to furnish the insured's insurance company all information which said Insurance Company may request.

I hereby assign to the Providers of Aceso Medical Clinic, LLC all insurance proceeds to which I am entitled for medical and/or surgical expense relative to the services performed. I understand that this assignment does not relieve me from responsibility for charges not paid by my insurance company.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

OFFICE POLICIES, PLEASE READ CAREFULLY

Thank you for choosing Aceso Medical Clinic, LLC for your medical care. We are committed to providing you with the best care possible. In order for us to provide quality healthcare, you the patient have some responsibilities.

1. Please arrive 15 minutes prior to your appointment. If you arrive more than 10 minutes late you may be asked to reschedule. **It is your responsibility to call 24 business hours in advance to cancel or reschedule your appointment**. Failure to give 24-hour notice or not showing up for your appointment will result in a late cancel/no show charge. ***Please note that your insurance company will not cover this charge.***

    - **1st No Show – No Charge**
    - **2nd No Show - $25.00**
    - **3rd No Show - $100.00 and the possibility of the dismissal from practice**

2. Co-pays are due at the time of the service. We accept cash, check, and credit/debit cards. You will be charged a $35.00 fee if your check is returned for non-sufficient funds.
3. I understand that it is my responsibility to notify this office of any changes to my address, phone number and insurance information. Should I fail to supply this information in a timely manner I understand that this office may not be able to bill my insurance due to filing guidelines and I will be responsible for the full amount of the bill.
4. We will send the monthly billing statement to one household or one responsible party only. If two or more people from different households share financial responsibility for a client's medical expenses, we will bill only the person listed as the responsible party on the intake form. A party other than the client can only be designated if: the client is under the age of 18 or a power of attorney is presented stating someone else is responsible for the client. Payment in full is expected within 30 days of the date of your statement. If you are unable to pay your balance in full, please contact the billing phone number listed on your statement to make arrangements.
5. We will bill your insurance company as a courtesy to you and will follow up with them to assist in getting reimbursement for services. Should your insurance not cover all or part of your services you will be responsible for this amount.
6. If it is necessary to refer your account for collection, patient agrees to pay all reasonable attorney fees and collection costs including any collection fees charged by a collection agency, even though no suit or actions are filed. If a suit or action is filed the amount of such reasonable attorney's fees or collection charges shall be fixed by the court or courts in which the suit or action, including any appeal therein, is tried, heard, or decided. Should it be necessary you authorize the provider, provider representative and/ or a collection agency to request a credit report from all three credit bureaus.

Your signature below signifies that you have read and understand these policies. You may request a copy of these policies for your records. I understand that should I sign acknowledging these policies I will still be held accountable to these policies.

Signature: _____ Date: _____

ACKNOWLEDGMENT AND CONSENT

I understand the Aceso Medical Clinic, LLC located at 375 Park Ave. Suite 5, Coos Bay, OR (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the use and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

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HIPAA Privacy Release
Consent for Aceso Medical Clinic, LLC Care Coordinators

Right of Access for Family Member/Friend

Patient Name _____ **Date of Birth** _____/_____/_____

I authorize my medical service providers to disclose and release my protected health information (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing). This information may be released to:

	Name	Relation	Phone Number
1.			
2.			
3.			
4.			

Specific information **NOT** to be disclosed:

_____

_____

*This **Release of Information** will remain in effect until terminated by me in writing.*

_____ _____
Signature of the Individual Giving Authorization **Date**

Consent for Aceso Medical Clinic, LLC Care Coordinators

By signing below, I am giving Aceso Medical Clinic Care Coordinators permission to disclose my Protected Health Information (PHI) for continuation of care.

Examples of who Aceso Medical Clinic, LLC Care Coordinators may disclose my information to are but not limited to:

- Food Pantries
- Meals on Wheels
- Bay Cities Brokerage
- South Coast Business Employment Corporation

Examples of PHI Aceso Medical Clinic, LLC Care Coordinators may disclose but not limited to:

- Name
- Address
- Date of Birth
- Insurance

Aceso Medical Clinic, LLC Care Coordinators will **NOT** disclose any of our patients' diagnoses and/or any physician notes.

Patient Signature: _____ **Date:** _____

Parent or Legal Guardian Signature: _____ **Date:** _____

Name: _____ **DOB:** _____ **Age:** _____

Medication Allergies: _____

Current Medications: Name, Dose, & Frequency (Please include over the counter & herbal remedies)

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

Chronic Medical Condition(s):

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

Surgical History: (include dates)

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

Smoking History:

Have you ever smoked? Yes/No If yes, how many packs per day? _____
Do you currently smoke? Yes/No For how many years? _____

Alcohol History:

On average, how many alcoholic drinks do you consume? (Please check box)

☐ None ever ☐ <1 per week ☐ <1 per day ☐ 1-3 per day ☐ >3 per day

Drug History:

Have you ever injected drugs? Yes/No
Have you ever used drugs not intended for medical use? Yes/No

Immunizations:

Do you get a yearly flu vaccine? Yes/No Date of last flu vaccination: _____
When was your last Tetanus Booster? _____
Have you had Pneumonia Vaccine? Yes/No Date of last Pneumonia vaccination: _____

Family History:

Is your mother still living? Yes/No if deceased, at what age? _____ Cause: _____
What medical condition(s) does/did she have? _____
Is your father still living? Yes/No if deceased, at what age? _____ Cause: _____
What medical condition(s) does/did he have? _____
Have you ever had a colonoscopy? Yes/No if yes, what date? _____
If female, have you ever had a

- Mammogram? Yes/No If yes, what date: _____
- Pap? Yes/No If yes, what date: _____

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Brief health screen

Name: _____

DOB: _____

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink = 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

How many times in the past year have you had **4** or more drinks in a day? _____

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

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? _____

Mood:

	No	Yes
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○

(For the medical professional)

Interpreting the Brief screen:

Alcohol: Patients who answer 1 or more should receive a full alcohol screen (such as the AUDIT).

Drugs: Patients who answer 1 or more should receive a full drug screen (such as the DAST).

Mood: Patients who answer "Yes" to either question should receive a full screen for depression (such as the PHQ-9).

Note: The alcohol question asks about four drinks in one day to identify risky drinking among all patients, informed by the validation studies below, as well as a gender inclusive approach to patient care.

Citations:

McNeely J, Cleland C, Strauss S, Palamar J, Rotrosen J, Saitz R. "Validation of Self-Administered Single-Item Screening Questions (SISQs) for Unhealthy Alcohol and Drug Use in Primary Care Patients." J Gen Intern Med, 30, 1757–1764. 2015.

McNeely J, Strauss SM, Saitz R, Cleland CM, Palamar JJ, Rotrosen J, Gourevitch MN. A Brief Patient Self-administered Substance Use Screening Tool for Primary Care: Two-site Validation Study of the Substance Use Brief Screen (SUBS). Am J Med. 2015 Jul;128(7):784.e9-19. Epub 2015 Mar 10.

Flentje A, Barger BT, Capriotti MR, Lubensky ME, Tierney M, Obedin-Maliver J, et al. "Screening Gender Minority People for Harmful Alcohol Use." PLoS ONE. 15(4). 2020.

More resources: www.sbirtoregon.org

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

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Authorization for Disclosure of Protected Health Information

Date Information Desired by: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ email: _____

Maiden/Previous Names/ Nicknames: _____

Release Information From:

Provider/Facility Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Release Information to:

ACESO MEDICAL CLINIC, LLC
375 Park Ave. Suite 5, Coos Bay, OR 97420
Phone: (541) 808-3066 Fax: (541) 808-3280

Purpose of release:

☐ Continuing Medical Care
☐ Personal
☐ Other: _____

Information to be released:

Service Dates: **From:** _____ **To:** _____

☐ All Medical Records released will be limited to the last 3 years of information unless otherwise indicated. ☐ Physician Notes ☐ X-Ray ☐ Lab and/or Pathology, Mammography reports. ☐ Hospital Records/Consultations ☐ Worker's Comp Injury / MVA Records ☐ Colonoscopy/Endo reports ☐ Other : _____	**Must be INITIALED** to be included in other documents. _____HIV/AIDS related Records _____Mental Health Counseling and/or treatment information _____Genetic Testing Information _____Drug/Alcohol diagnosis, treatment, or referral information

PROVIDER INFORMATION

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization, or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this Authorization, please send a written statement to Aceso Medical Clinic Office Manager, 375 Park Ave. Suite 5, Coos Bay, OR 97420 and state that you are revoking this Authorization.

Unless otherwise specified _____ (date) your release of information will expire within 180 days.

ATTENTION: Please review the information below carefully. If information is missing the request may not be processed.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and lacks capacity to sign**, a legally authorized person may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)
  ☐ Personal Representative
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature (required):	Date Signed (required):
Printed Name of Person Signing (If not Patient):	