Coquille Valley Health - Orthopedics

2699 N 17th St. Coos Bay, Oregon 97420
Fax: 541-267-5152

INITIAL HISTORY SURVEY

Scan To: Facesheet

PLACE PATIENT STICKER HERE
Patient Name: _____
DOB: _____
MED REC #: _____
Physician: _____

Legal Name (First, Middle, Last): _____ Date: _____

How would you prefer to be addressed (nickname/short name): _____ ☐ Male ☐ Female

SS#: _____ DOB: _____ Oregon Driver's Lic. #: _____

Physical Address: _____ E-Mail: _____

Billing Address: _____

City/St/Zip: _____ Home Phone: _____ Cell Phone: _____

Ethnicity Questions: Do you consider yourself? ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Declined

Race Questions: Which category best describes your race? ☐ White ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander

☐ Black/African American ☐ American Indian/Alaska Native

Preferred language: ☐ English ☐ Spanish ☐ Other _____

Employer: _____ Occupation: _____

Address: _____

City/St/Zip: _____ Work Phone: _____

Spouse's Name: _____ Spouse's DOB: _____

Spouse's Employer: _____ Occupation: _____

Emergency Contact: Name _____ Phone: _____

Today's visit will be billed to: ☐ Regular Medical Insurance ☐ Worker's Comp. ☐ Motor Vehicle Accidental Liability ☐ Self-Pay

RESPONSIBLE PARTY

☐ Self ☐ Parent OR ☐ Other _____

Name of Responsible Party: _____ DOB: _____ SS#: _____

Address: _____

City/St/Zip: _____ Home Phone: _____ Work Phone: _____

Employed By: _____ Occupation: _____ Length of Employment: _____

MEDICAL INSURANCE INFORMATION

Insurance Co. #1: _____ Mailing Address: _____

Ins. Co. Phone: _____ Group #: _____ SS or ID #: _____

Subscriber Name: _____ Address: _____ DOB: _____ Sex: ☐M ☐F

Insurance Co. #2: _____ Mailing Address: _____

Ins. Co. Phone: _____ Group #: _____ SS or ID #: _____

Subscriber Name _____ Address: _____ DOB: _____ Sex: ☐M ☐F

WORKER' S COMPENSATION

For Worker's Compensation, claim is: ☐ Open ☐ Closed ☐ New ☐ Disputed

Insurance Co. Name _____ Address: _____ City/St/Zip: _____

Claim #: _____ Injury Date: _____ SS or ID #: _____

Employer Name at Time of Injury: _____ Last Day Worked: _____

MOTOR VEHICLE ACCIDENT/LIABILITY

Motor Vehicle Accident/Liability

Name of Insured: _____ Policy/Claim #: _____

Insurance Name & Address: _____ Phone #: _____

Agent Name: _____ City/State: _____ Date of Accident: _____

2699 N 17th St. Coos Bay, Oregon 97420
Fax: 541-267-5152

CONDITIONS OF ADMISSION

Scan To: Conditions of Admission

PLACE PATIENT STICKER HERE
Patient Name: _____
DOB: _____
MED REC #: _____
Physician: _____

Consent to Medical and Surgical Procedures: The undersigned consents to the procedures which may be performed during your patient visit and any other treatment or services, which may include but are not limited to procedures, anesthesia, or other services rendered to the patient under the general and special instructions by the patient's provider. The undersigned has the ability at any time to withdraw their consent by making their wishes known to the care team.

Patient Identification and Images: When deemed appropriate for your medical care, Patient understands and consents to having images (digital, film, etc.), taken of Patient and Patient's wounds and or injuries with their surrounding anatomical features. These images are taken for treatment purposes, including the ability to monitor the progress of treatment and to provide continuity of care. These images may be considered protected health information (PHI) and will be handled, maintained, and retained in a confidential, secure, and protected manner in accordance with applicable laws, regulations, and Clinic privacy and retention policies. Patient understands that Coquille Valley Health will retain ownership rights to these images and Patient expressly waives any and all rights to royalties or other compensation for these images. Patient understands that Patient may view or obtain copies of the images in accordance with applicable laws, and policies.

Release of Information: The clinic will obtain the patient's consent and his/her written authorization to release information concerning the patient, except in those circumstances when the clinic is permitted or required by law to release information.

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the clinic may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the clinic charges, including but not limited to insurance companies, healthcare service plans, or workers' compensation carriers. Special permission is needed to release this information if the patient is treated for alcohol or drug abuse.

Restricted Items: Firearms and illegal drugs are not permitted in the facility.

Financial Agreement: The undersigned agrees whether he/she signs as an agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay their personal account in accordance with the regular rates and terms of the organization. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

Assignment of Insurance Benefits: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to the clinic of any insurance benefits otherwise payable to or on behalf of the patient for outpatient services, including emergency services if rendered, at a rate not to exceed the organizations actual charges. It is agreed that payment to the organization, pursuant to this authorization by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. It is understood by the undersigned that he/she is financially responsible for charges not paid pursuant to this assignment.

2699 N 17th St. Coos Bay, Oregon 97420
Fax: 541-267-5152

CONDITIONS OF ADMISSION

Scan To: Conditions of Admission

PLACE PATIENT STICKER HERE
Patient Name: _____
DOB: _____
MED REC #: _____
Physician: _____

Healthcare Service Plan Obligation: This organization maintains a list of healthcare service plans with which it contracts. A list of such plans is available upon request from the financial office. The organization has no contract, express or implied, with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by the clinic if he/she belongs to a plan which does not appear on the above-mentioned list.

I grant permission and consent to Coquille Valley Health and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, whether provided by me or obtained on its own; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text messages or emails using any email address or phone number associated with me, whether provided by me or obtained on its own; and (4) to use prerecorded/artificial voice messages and/or automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I further agree to provide updated contact information in an effort to avoid unintended disclosures of my information and I accept and acknowledge that Coquille Valley Health and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations) will treat any email address or phone number obtained as my private email or phone number that is not accessible by unauthorized parties. I understand that these communications may result in charges to me by my mobile service provider and are not encrypted. I understand communication attempts will be made with the cellular phone number provided unless notified otherwise. I understand that my refusal to provide the information described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date: _____ Time: _____ AM/PM

Signature: _____
(Patient/Parent/Conservator/Guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____

Patient to Initial Application Box:

YES	NO	
☐	☐	I have given accurate information regarding my Medicare Benefits
☐	☐	I have been informed of my Patient Bill of Rights, Visitation rights and responsibilities

YES	NO	
☐	☐	Copy provided to the patient?