NORTHWEST ENDOCRINOLOGY, LLC
6485 SW BORLAND RD, SUITE E, TUALATIN, OR 97062
800-363-6499 (voice), 866-600-0813 (fax)

Patient Demographic Form (Please PRINT)

MRN **Date**

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial** | **Nickname/AKA**

Date of Birth | **Gender** [ ] Male [ ] Female

Marital Status [ ] Married [ ] Single [ ] Divorced [ ] Life Partner [ ] Separated [ ] Widowed [ ] Other | **Preferred Language**

Race (Optional) [ ] Black – Non Hispanic [ ] American Indian/ Alaskan Native [ ] Hispanic [ ] Asian/Pacific Islander [ ] White – Non Hispanic [ ] Other

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** [ ] Cell [ ] Pager [ ] Fax

Email Address | **Employment Status** [ ] Active Duty Military [ ] Child [ ] Disabled [ ] Employed Full-Time [ ] Employed Part-Time [ ] Homemaker [ ] Not Employed [ ] Retired [ ] Self Employed [ ] Student Full-Time [ ] Student Part-Time [ ] Other

Employer | **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician | **Referring Physician**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient [ ] Self (If self, skip to Emergency / Next of Kin) [ ] Spouse [ ] Parent [ ] Other

Last Name | **First Name** | **Middle Initial**

Date of Birth

Home Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** [ ] Cell [ ] Pager [ ] Fax

Employer | **Employment Status** [ ] Active Duty Military [ ] Child [ ] Disabled [ ] Employed Full-Time [ ] Employed Part-Time [ ] Homemaker [ ] Not Employed [ ] Retired [ ] Self Employed [ ] Student Full-Time [ ] Student Part-Time [ ] Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** [ ] Cell [ ] Pager [ ] Fax

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name | **First Name** | **Relationship to Patient**

Address | **Apt #** | **City** | **State** | **Zip Code**

Home Phone | **Work Phone** | **Other Phone** [ ] Cell [ ] Pager [ ] Fax

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Services and Financial Agreement and Consent

1. **Contact Information**
   - We depend on accurate contact information for emergencies and billing. Please keep your contact information current and updated at all times.
2. **Receiving Service**
   - Please bring and present your current health insurance card(s) at each visit.
   - Your contact information will be validated at each visit.
3. **Billing Insurance**
   - Our office will bill validated **primary** insurance as a courtesy, *but the patient is responsible for their account*.
4. **Payment for Service**
   - All co-pays, co-insurances and outstanding balances *will be due at the time of service*.
   - We require a valid credit card to be kept on file to cover any balance (please review the Credit Card on File Policy for more specific information). Patients who are unable to provide a credit card to be kept on file will be required to pay, in addition to co-pay/co-insurance, a minimum deposit (cash or check) of $100.00 (may be more based on type of service). Exact deposit amounts for specific services will be available for review at time of check-in.
   - We accept cash, checks, money orders and most credit and debit cards.
   - If you have no insurance, then payment in full is required at the time of service (a self-pay discount may apply).
5. **Payment Problems**
   - NSF (non-sufficient funds) or checks returned for any reason will incur a $25.00 fee. You will receive a notice and must pay the amount owed and the NSF/Returned check fee within 10 days of the date of the notice.
   - If an account balance remains unpaid after 90 days, we reserve the right to refer the account to an outside collection agency. If your account is referred to collections, you may be subject to discharge from our practice.
6. **Arrivals, Cancellations and Missed Appointments (no-shows)**
   - *We require 24-hour notice if you need to cancel and/or re-schedule your appointment*. Failure to provide this notice will result in the following charges (not covered by your insurance):
     $75.00 for follow-up appointment missed or canceled without proper notice
     $200.00 for new patient/consult appointment, ultrasound or biopsy missed or canceled without proper notice
   - Patients who accumulate three missed appointments may be subject to discharge from our practice.
7. **Copies of Medical Records and Other Forms**
   - Record requests are generally fulfilled within five business days (but may take up to thirty days based on the type of request).
   - If the request is addressed/fulfilled at the time of service, the patient will generally not incur any fee.
   - If the request is more involved and/or is not addressed at the time of service, a fee may be incurred.
   - Fees for these services are available for review prior to request being fulfilled. Patients will be required to sign an authorization to release information if the records are not being released to the patient. The form is available in the office or can be mailed to you to complete and return to us with your signature and instructions.

My signature below indicates that I have read, acknowledge and understand the policies explained above and have received a copy of this information. I authorize my insurance company or companies to pay Northwest Endocrinology, LLC and its providers directly. A copy of this authorization can be considered an original for insurance purposes. I hereby authorize Northwest Endocrinology, LLC, to keep my credit card information on file and to utilize it for payment of any and all charges for medical services for which I am financially responsible and that remain unpaid after applying insurance payments and adjustments, if any. I do hereby consent to and authorize the performance of all examinations, treatments and medical services by Northwest Endocrinology, LLC, its providers and staff which may be deemed advisable.

______________________________ ______________________

Signature **Date**

______________________________ ______________________

Printed Name **Relationship to Patient**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from Northwest Endocrinology, LLC. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by visiting our website at www.northwestendocrinology.com or on request from our staff.

I acknowledge receipt of the Notice of Privacy Practices from Northwest Endocrinology, LLC.

Print Name: ______________________________________

Signature: _______________________________________ Date: ____________
(Patient / Parent / Guardian)

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Patient's Authorization to Release Medical Information

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designation the parties below with whom I wish the Northwest Endocrinology, LLC, its physicians and staff, to be able to discuss my medical condition.
If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform the Northwest Endocrinology, LLC, its physicians and staff, in writing, of my decision.
I accordance with the above, I, ____________________________________, hereby authorize the Northwest Endocrinology, LLC, its physicians and staff, to discuss with and release my medical information to the following individuals:

_____________________________________ _________________________________

_____________________________________ _________________________________

The below individuals are authorized to pick up any written prescriptions, medication samples, or x-ray films on my behalf.

_____________________________________ _________________________________

_____________________________________ _________________________________

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is it be excluded.

_____________________________________ _________________________________

_____________________________________ _________________________________

Patient Signature:____

Date:________________________ Witness:____