ACKNOWLEDGMENT AND CONSENT

I understand that **Grants Pass Clinic, LLP**, (referred to below as GPC) 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 GPC 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 others 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 GPC will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of GPC, 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 Practices. I also understand that a copy or a summary of the most current version to GPC's Notice of Privacy Practices in effect will be posted in waiting/reception areas and available on the website at www.grantspassclinic.com.

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 GPC 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. I also understand that if I do not sign or return this Acknowledgment, I am not agreeing to the Privacy Practices and GPC can no longer provide service to me.

By:_____ Date:_____
(Patient Signature)

_____ Date of Birth: _____
(Print patient's name)

-OR-

By:_____ Date:_____
(Patient representative)

Patient's Name:_____ Date of Birth: _____
Description of Representative's Authority_____

Grants Pass Clinic, LLP
Financial Policies

The following is our financial policy and we require you read and sign this agreement prior to any treatment.

Insurance - Grants Pass Clinic currently contracts with the following insurance plans:

Atrio	First Choice Health Network	Health Net Health Plan
Lifewise	Moda Health	Pacific Source
Providence Health Plans	Regence BlueCross BlueShield	United Healthcare

Contracted insurances are subject to change without notice. It is the patient's responsibility to confirm coverage and benefits directly with their insurance carrier.
If your insurance is not listed above, as a convenience, we will file your claim to your insurance company. We expect payment from your insurance within ninety days; remaining balances at that time may be transferred to your personal account and considered due and payable in full.

It is your responsibility to make sure we have accurate insurance information. If a claim is unsuccessful because of invalid insurance information, or in situations where you have not reported your insurance change and it ultimately results in an unpaid claim due to insurance timely filing, you will be responsible for the balance.

Authorization - If your insurance plan requires a referral or treatment authorization from a primary care physician, it is ultimately your responsibility, as the patient, to ensure that the proper referral has been obtained. Any treatment without the necessary referral may result in a denial of payment by the insurance company, which could make payment for all charges your responsibility.

Payment Arrangements - Financial arrangements may be extended upon advance approval by the credit office. The minimum monthly payment is 10% of the account balance due, or $25.00, whichever is greater. Monthly payments are in addition to co-pays you may incur on future appointments. Not all services are available on a credit basis and some services may require all or partial payment in advance. Should your account be placed in collection, we reserve the right to dismiss you and any members of the account from our practice.

Payment Options - Our office accepts check, cash, Visa, MasterCard, or Discover. There will be a $25.00 fee for all returned checks.

If you need assistance or have billing questions, please contact our Business Office at 541-472-5580.

Acknowledgement and Release of Benefits and Information

I have read and understand the above policies. I authorize my insurance benefits to be paid directly to the Grants Pass Clinic, LLP. I understand that I am financially responsible for any balance due. I understand I am responsible to pay all applicable co-pays and deductibles at the time of the office visit. I authorize Grants Pass Clinic or the insurance company to release any information required for the purpose of paying this claim.

Even though an insurance claim may be pending I will receive a statement each month if my account has an outstanding balance. I acknowledge that I am responsible and obligated to pay this account in full. In the event of non-payment, as the responsible party on this account I shall be responsible for the cost of collection, including court costs and reasonable legal fees, should this be required.

Responsible Party Date

Please Print Name

Grants Pass Clinic, L.L.P.
495 SW Ramsey Ave. • Grants Pass, OR 97527 • (541) 476-6644

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION — Child 1

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 2

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 3

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

PATIENT INFORMATION — Child 4

PATIENT'S FULL NAME Last	First	Initial	Sex M F
Address _____ ✓ if same as Child 1			DOB
City	State	Zip	Home Phone

Who has legal custody of patient(s): ____ Parent____ Mother Only____ Father Only____ Foster Parent____ Grandparent
*If not biological/natural parents, court documents must be present at time of visit

PARENT- LEGAL GUARDIAN Last Name	First	Initial
Address _____ ✓ if same as patient		DOB

City	State	Zip	Home Phone	Driver's License
Employer	Work Phone	Occupation		

- Continued on Back -

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY Last Name	First	Initial	Relationship to patient
Address _____ ✓ if same as patient			DOB
City	State	Zip	Home Phone	Driver's License
Employer	Work Phone	Occupation

PATIENT EMERGENCY CONTACT

Contact Name	Relationship
Emergency Contact Address	Phone	Alternate Phone
City	State	Zip

INSURANCE INFORMATION

Primary Insurance Carrier	Member ID	Group No.
Subscriber Name:	Subscriber DOB	Group Name:
Secondary Insurance Carrier	Member ID	Group No.
Subscriber Name	Subscriber DOB	Group Name

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT

_____ _____

Signature *Date*

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY Last Name	First	Initial	Relationship to patient
Address _____ ✓ if same as patient			DOB
City	State	Zip	Home Phone	Driver's License
Employer	Work Phone	Occupation

PATIENT EMERGENCY CONTACT

Contact Name	Relationship
Emergency Contact Address	Phone	Alternate Phone
City	State	Zip

INSURANCE INFORMATION

Primary Insurance Carrier	Member ID	Group No.
Subscriber Name:	Subscriber DOB	Group Name:
Secondary Insurance Carrier	Member ID	Group No.
Subscriber Name	Subscriber DOB	Group Name

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE AND CORRECT

_____ _____

Signature *Date*

Grants Pass Clinic, LLP
495 SW Ramsey Avenue
Grants Pass, OR 97527
541-472-5560

PARENTAL CONSENT FORM

I give permission for_____
Representative's Name

OR_____ OR _____
Representative's Name *Representative's Name*

to take my child:_____ _____
Child's Name *Child's Date of Birth*

to Dr._____or the covering physician at Grants Pass Clinic, LLP.

I also give permission for the physician to examine and treat my child. I designate that the above named representative(s) may receive protected health information regarding my child and their visit to the doctor.

My child has the following drug allergies:_____

_____

_____ _____
Signature of Parent or Guardian *Date*

Right to Revoke: If you decide you do not want the person(s) named above to continue to act on behalf of your child you have the right to revoke this permission. Any revocation can only apply on or after the date that we receive your Revocation.

REVOCATION:

I no longer want the person(s) named above to act on behalf of my child. All permissions listed above are no longer applicable.

Signature_____Date_____

Grants Pass Clinic, L.L.P.

MRN_____

495 SW Ramsey Avenue, Grants Pass, OR 97527
541-476-6644

Grants Pass Clinic FollowMyHealth Pediatric Proxy Account Authorization

Note: Person requesting access must be patient or legal representative

PATIENT'S INFORMATION

Patient Name_____ Date of Birth_____

Address_____ City, State, Zip_____

Email address:_____ Phone:_____

PARENT/LEGAL GUARDIAN INFORMATION

Proxy's Name_____ Date of Birth_____

Address_____ City, State, Zip_____

Proxy's Email Address:_____ Phone:_____

Proxy's Relationship to Patient: _____

Terms and Conditions

I understand that FollowMyHealth contains limited, select information from a patient's record and does not reflect the entire contents of the medical record. A patient may request a copy of his/her medical record from Grants Pass Clinic.

This form only authorizes access through FollowMyHealth and does not authorize release of my medical record to my designated proxy by other methods or in other formats.

I understand that access to FollowMyHealth is provided by Grants Pass Clinic as a convenience to their patients and that Grants Pass Clinic has the right to deactivate access at any time for any reason.

I understand that due to privacy regulations I will only have access to my child's record until they are age 15. From ages 15-17 it is required that the patient specifically indicate whether they permit their parent(s) or guardian(s) to have access to their patient portal information via a signed authorization (Adult Patient Proxy) that will expire at age 18.

Patient/Legal Representative Signature: _____ Date:_____

(Must be signed in person at Grants Pass Clinic)

Grants Pass Clinic FollowMyHealth

Connecting to Your Minor's Medical Information

Grants Pass Clinic's FollowMyHealth will give you the ability to communicate with your child's doctor and access their medical information.

Please follow the steps below to set up your proxy access:

1. Check your email for a FollowMyHealth proxy invitation
2. Click on the registration link provided in the email
3. If you have your own FollowMyHealth Universal Health Record, click on the "Already a FollowMyHealth user? Sign in and add this connection" option.
4. If you do not have a FollowMyHealth Universal Health Record, click on the "First time using FollowMyHealth? Sign Up and Connect" option.
    - Verify your Notifications Email, First Name, Last Name, Date of Birth, Zip Code, and select "Confirm and Continue."
    - Review the "Terms of Use" and select the "I Accept" option.
    - Create your Username and Password (your email address will default as your username- you can change this value if you do not want to use your email address) and click on the "Confirm and Continue" option.
    - Enter your invite code (this is the four digit year of birth of the oldest/only child.) If you need assistance with your invite code, please contact our Grants Pass Clinic FollowMyHealth support team at 541-472-5566.
    - Accept the Release of Information, Individual Acceptance, and Authorization.
    - You are now logged into your chart.
    - Your name is the primary account.
    - Navigate to the drop down menu located in the upper right hand corner (currently your name) and select a name from this list to view that chart.
    - The "Home" tab offers general information along with upcoming/previous appointments
    - The "Inbox" tab allows the send/receive email functionality
    - The "My Health" tab displays summary, medication, allergies, and immunization records that can all be printed, faxed, or emailed

**** Click on the Inbox tab, Compose, select your doctor from the "To" dropdown, and send an email to let your doctor know you are connected to FollowMyHealth ****