TUALITY HEALTHCARE
An OHSU Partner

Hillsboro Internal Medicine
Hillsboro Surgical Associates
Hillsboro Hematology & Oncology
Orenco Station Medical Group
Tuality Obstetrics & Gynecology

PATIENT REGISTRATION

PATIENT INFORMATION:

Name:
First M.I. Last

Birth Date: **Age:** **Sex:** **Soc. Sec. Number:** **Marital Status:**

Home Phone: **Work/Daytime Phone:**

Employer: **Occupation:** **Drivers Lic:**

Home Mailing Address:
Street
City State Zip

Physical Address (if different from Mailing Address)
Street City, State Zip

Email Address:

Advance Directives
If you have an advance directive please forward a copy to us.

If not, would you like assistance in filling one out? Yes No

Rights and Responsibilities

I would like a copy of the patient Rights and Responsibilities

Yes No

If yes, information given to patient / family _____ (Initials) Date _____

Genetic Research Notice

I have received the Genetic Research Opt-Out Notification.

Yes No

PARENT or RESPONSIBLE PARTY (if other than patient):

Name:
First M.I. Last

Home Phone: **Work Phone:**

Mailing Address:
Street
City State Zip

Birth Date: **Soc. Sec. Number:**

Employer:

Relationship to Patient:

IN CASE OF EMERGENCY

Name of a friend or relative (circle one) not living with you who can be contacted in case of emergency:

Name: **Phone:**

PLEASE TURN OVER...

Please provide the front office with your insurance card(s) and your driver's license.

INSURANCE INFORMATION

Are you being seen for a motor vehicle accident or a work injury? Yes No

Do you have a co-payment? Yes No Amount $_____

Primary Insurance Company: _____ **Group #** _____ **ID#** _____

Name of Insured: _____ **Date of Birth** _____ **Relationship to Patient** _____

Secondary Insurance Company: _____ **Group #** _____ **ID#** _____

Name of Insured: _____ **Date of Birth** _____ **Relationship to Patient** _____

CREDIT AND PAYMENT POLICY

Patients are responsible for all charges resulting from treatment. As a service to you, we will bill most insurance carriers. Co-payments, set by your insurance plan, are due at the time of service. Payment of account balances not covered by insurance are due within 30 days, unless other arrangements are made. Established patients with a delinquent balance will be asked for payment at the time of service. If you are unable to pay, your appointment may be rescheduled. Patients referred from the Tuality Community Hospital or Tuality Forest Grove Hospital emergency room will be treated regardless of their ability to pay at the time of service.

New, non-insured, patients are required to pay **$80.00** toward their first appointment's charges at the time of service. The remaining balance will be billed to the patient. Established, non-insured, patients are required to pay **$50.00** toward each appointment's charges. The remaining balance will be billed to the patient.

Assistance may be available if you are unable to pay for service due to financial hardship. Please request information from the receptionist.

MEDICARE: The physicians in this office are participating providers with Medicare.

OREGON HEALTH PLAN: To receive treatment you must currently be covered by the Oregon Health Plan and assigned to a health plan with which this clinic participates. Proof of coverage is required at the time of service.

WORKER'S COMPENSATION: Payment for treatment attributed to a work injury is payable in accordance with applicable laws. Patients are responsible for payment for treatment if a claim is denied.

CONSENT - AUTHORIZATION TO RELEASE INFORMATION - ASSIGNMENT OF BENEFITS - AGREEMENT/CONTRACT

I consent to and authorize all treatment that may be considered necessary or advisable by the physicians.

I hereby authorize Tuality Healthcare and/or the physician to release to my insurance company any information acquired in the course of my treatment in accordance with applicable law. I also authorize release of information to business associates by Tuality Healthcare and/or the physician as necessary to carry out treatment, payment or healthcare operations, including release to Tuality Health Alliance and groups that do utilization management or utilization quality management.

I have provided the office with a current copy of my insurance card(s).

I hereby agree to full responsibility for all expenses incurred and hereby assign to Tuality Healthcare and the doctor, any and all insurance benefits due this patient to the full extent of my financial obligation to said doctor.

I understand insurance coverage is a relationship between the insured and their insurance company and I agree to accept financial responsibility for payment for charges incurred. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that I may be billed for appointments not cancelled at least 24 hours in advance, and that the insurance plan will not pay for missed appointments. Responsibility for payment of treatment related to work injuries shall be governed by applicable laws.

Patient Signature: _____ **Date:** _____
(parent or guardian signature if patient is a minor)

Please print name: _____

Please provide the front office with your insurance card(s) and your driver's license.