Women's Healthcare Clinic of Oregon, P.C.
COLLECTION POLICY

To our patients – Thank you for allowing us to be of service to you. Non-payment of medical bills has a direct effect on you, your community, and the medical provider. Therefore, we have implemented the following policies:

Insurance Billing – We agree to bill primary and secondary insurance carrier(s) for you, *if* you bring all necessary information needed at the time of service. Requests for re-filing claims, due to incorrect information provided, will result in a $10.00 re-filing fee.

Billing Policy – We will provide you with an itemization of services rendered within thirty days of service or after the insurance payment is received.

Payment Policy – We ask that you pay your co-payments upon check-in and all co-insurance amounts (due by patient) within thirty days of insurance reimbursement. Uninsured patients will be expected to pay 100% of charges (less 20% for cash discount) at the time of service. We accept payments in the forms of cash, check, VISA, MasterCard, or bank debit cards. *There is a $5.00 per month re-billing fee for patient balances not paid within 60 days from the date of service, until balance is paid in full, or the account is referred to an outside agency.*

Collection Policy – All patient balances not paid in accordance with the payment policy noted above, may be referred to an outside collection agency. *Whether or not litigation is instituted to collect the amounts owed, you and/or your responsible party will be liable for all reasonable collection agency fees charged and any related expenses incurred in connection with any related legal action to collect amounts owed.*

Returned Check Charges – Should a check be returned for any reason, a fee of $20.00 will be charged. If necessary to collect the amount of the check, it may be assigned to a collection agency or referred to an attorney. In the event that the amount is forwarded to an outside agency, the writer of the check shall be liable for the face value of the check, including any collection charges as stated above, and any other damages or charges permitted under applicable law.

There will be a $25.00 charge for missed appointments that are not cancelled 24 hours prior to the appointment time. Timely cancellations allow our office to offer that time to someone on our waitlist.

Signed:____ Date:____________

RELEASE AUTHORIZATION

I HEREBY AUTHORIZE WOMEN'S HEALTHCARE CLINIC OF OREGON, P.C. to furnish the insured's insurance company all the information which said insurance company may request concerning my present medical condition. I hereby assign to the said doctor and/or surgical expense relative to the services performed from time to time, but not to exceed my indebtedness to said physician and/or surgeon. I understand that I am financially responsible to said doctor for charges not covered by this agreement.

Signed:____ Date:_____________

WOMEN'S HEALTHCARE CLINIC OF OREGON, P.C.

Physicians & Surgeons || Obstetrics & Gynecology

10000 SE Main St., Ste. 236, Portland, OR 97216

Phone (503) 256 – 1470 || Fax (503) 256 - 1283

Doctor: ____________________ *Patient ID #:*

PATIENT INFORMATION

Name: ____________________

Address: ____________________

City,State, Zip: ____________________

Pharmacy Name & Address: ____________________

Ethnicity: [ ]Hispanic or Latino [ ]Non Hispanic or Latino [ ]Other

Race: ☐ Asian ☐ American Indian or Alaska Native ☐ White ☐ Native Hawaiian or Other Pacific Islander

Date of Birth: ________ Age: ______ Sex: [ ]M [ ]F

Social Security #: ____________________

Phone: ____________ [ ]Home [ ]Work [X]Other

Phone: ____________ [ ]Home [ ]Work [X]Other

Phone: ____________ [ ]Home [ ]Work [X]Other

Marital Status: [ ]Married [ ]Single [ ]Divorced

Email Address: ____________________

Preferred Language: ____________________

☐ Black or African American

☐ Unspecified ☐ Patient Declined

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [X]Other

Employer's Name: ____________________

Employer's Phone: ____________________

Occupation: ____________________

Referring Physician: ____________________

Primary Physician: ____________________

EMERGENCY CONTACTS

Name	*Relationship*	*Phone*

RESPONSIBLE PARTY *(If patient is under 18 years of age)*

Name: ____________________

Address: ____________________

City,State, Zip: ____________________

Employer: ____________________

Home Phone: ____________________

Work Phone: ____________________

SSN: ____________________

Date of Birth: ____________________

PRIMARY INSURANCE

Insurance Company Name: ____________________

ID #: ____________________

Group/Policy #: ____________________

Subscriber's Name: ____________________

Subscriber's Phone #: ____________________

Relationship to Patient: ____________________

Subscriber's Employer: ____________________

Subscriber's SS #: ____________________

Subscriber's Date of Birth: ____________________

SECONDARY INSURANCE

Insurance Company Name: ____________________

ID #: ____________________

Group/Policy #: ____________________

Subscriber's Name: ____________________

Subscriber's Phone #: ____________________

Relationship to Patient: ____________________

Subscriber's Employer: ____________________

Subscriber's SS #: ____________________

Subscriber's Date of Birth: ____________________

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. ***I understand that I am responsible for any amount not paid for by my insurance.***

____________________ PATIENT/GUARDIAN SIGNATURE ____________________ DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

____________________ PATIENT/GUARDIAN SIGNATURE ____________________ DATE

Date ______________________

New Patient / Well Woman Intake Form

Full Name _________________________________ Preferred Name __________________________ Age______

Pronouns: She/her He/him They/them Sexual Orientation _________________ Partners: Male / Female / Both

Primary Care Doctor ________________________

GYN History

First day of last menstrual period ___/___/_____
Most recent:
Pap smear ___/___/_____ Normal: Yes No
HPV screening ___/___/_____ Normal: Yes No
Mammogram ___/___/_____ Normal: Yes No
Colonoscopy ___/___/_____ Normal: Yes No
Bone density screening ___/___/_____ Normal: Yes No

History of Gardasil (HPV) vaccination Yes No
History of sexually transmitted infection Yes No
(i.e., chlamydia, gonorrhea, trichomonas, genital herpes, genital warts)

Age of first menstrual period ______
I have a period monthly. Yes No
My period lasts ____days.
Number of days between 1st day of each period _____
My period is heavy. Yes No
My period is painful (cramps). Yes No
Are the cramps Mild Moderate Severe
Spotting or bleeding between periods Yes No

Sexually active Yes No
If yes, with men, women, or both? ______________
Are you postmenopausal? Yes No
If yes, have you had post-menopausal Yes No

Current Birth Control

__ Rhythm method/ withdrawal __ Condoms/ diaphragm
__ Pills/ patch/ ring __ IUD __ Arm implant
__ Tubal Ligation __ Vasectomy __ None needed
Prior birth control used ______________________________
I'm planning/ currently trying to conceive Yes No
If yes, how long have you been trying? _______________

Have you been hospitalized or had surgery since your last annual exam? Yes No
If yes, please explain _______________________________

Do you exercise? Yes No
Type of exercise _______________ Times/ week _______

Over the past two weeks, have you felt down, depressed, or hopeless? Yes No
Over the Past two weeks, have you felt little interest or pleasure in doing things? Yes No

Any specific concerns you'd like to discuss today?
____

Medications:
Include herbs, vitamins, supplements, aspirin, and any over-the-counter medications.

Name	Dose	Frequency

Allergies __ No known allergies

Medication	Reaction

Family History

Please note the relation.

Asthma _____________ Breast cancer _____________
Diabetes ____________ Ovarian cancer ____________
Heart disease _________ Colon cancer _____________
Clotting disorder _______ Uterine cancer ___________
High Blood pressure________ Lung disease _______
Seizure disorder ___________ Renal disease ________
Thyroid disease ___________ Stroke _______________
Osteoporosis _____________ Other ________________
____

Social History

Marital status _____________ Living with ___________
Education degree __________ Occupation ___________
Job status ________________
Within the past year:
Has anyone hit, slapped, kicked, or otherwise physically hurt you? Yes No
Has anyone forced you to have sexual activities? Yes No

Tobacco

Cigarettes Current Quit Never
If current, how many packs/ day? ___________
__ E-Cigarettes __ Smokeless/ chewing
I would like more info about quitting. Yes No
Alcohol: Yes No
If yes, how many glasses/ week? _________
Have you ever felt the need to cut down? Yes No

General	Fever		**Musc/Skel**	Muscle Weakness	
	Chills			Muscle or Joint Pain	
	Sweats			Back Pain	
	Weight Loss		**Skin**	Acne	
	Weight Gain			Rash	
	Fatigue			Non – Healing Sore	
Eyes	Vision Changes			Dry Skin	
ENT	Headache			Pigmented Lesions	
	Throat Pain		**Breast**	Breast Pain	
	Frequent Headaches			Nipple Discharge	
Heart	Chest Pain			Masses	
	Leg Swelling			Breast Tenderness	
	Palpitations		**Neuro**	Dizziness	
Respiration	Wheezing			Weakness	
	Coughing up Blood			Numbness	
	Shortness of Breath		**Psych**	Depressed Mood	
	Cough			Cries Easily	
Gastrointestinal	Diarrhea			Irritability	
	Bloody Stool			Severe Anxiety	
	Nausea/Vomiting/Indigestion			Trouble Concentrating	
	Constipation		**Endocrine**	Hot Flashes	
	Flatulence (Gas)			Hair Loss	
	Abdominal Pain			Heat/Cold Intolerance	
	Abdominal Bloating			Unusual Weight Changes	
	Heartburn			Excessive Thirst	
GYN	Vaginal Discharge			Excessive Hunger	
	Painful Periods		**Hem/Lymp**	Bruises	
	Painful Intercourse			Bleeding	
	Painful Bowel Movements			Enlarged Lymph Nodes	
	Abnormal Vaginal Bleeding		**Allergy**	Congestion	
	Heavy Menstrual Bleeding			Runny Nose	
	Missed Periods		**Other**		
Urinary	Blood in Urine				
	Painful Urination				
	Urgency				
	Frequency				
	Urinary Leaking				

PLEASE MARK ALL THAT **CURRENTLY** APPLY AND GIVE TO NURSE AT APPOINTMENT

NAME______________________________________ DATE__________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: ______________________________
(First) (Middle) (Last)

Date of Birth: ____________________ **Social Security Number:** ____________________

Any Previous &/or Other Name(s): ______________________________

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

☐ TO ☐ FROM

Sharon E. Wong, MD
Women's Healthcare Clinic of Oregon, PC
10000 SE Main St Ste. 236 Portland, OR 97216
(P) 503-256-1470 || (F) 503-256-1283

☐ TO ☐ FROM ______________________________

____

____

PURPOSE OF RELEASE (Please Check)**:**

☐ Changing Clinic ☐ Continuing Care ☐ Legal ☐ Other: ____________________
(Please Specify)

PERMISSION TO FAX INFORMATION ☐ **YES** ☐ **NO**

I specifically consent to the faxing of my records. All faxed materials will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot always be guaranteed.

If we are requesting this authorization from you for our own use and disclosure, or to allow another health care provider, or health plan to disclose information to us:

1. We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
2. You may inspect a copy of the protected health information to be used or disclosed;
3. You may refuse to sign this authorization;
4. We must provide you with a copy of the signed authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing and with the exception that we have not already used and disclosed the information as instructed by this authorization.

Unless revoked earlier or otherwise indicated, this authorization will expire in 90 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

TYPE OF INFORMATION TO BE RELEASED

ALL ITEMS BELOW ☐

☐ Medication Summary
☐ Consultations
☐ Discharge Summary
☐ History & Physical
☐ Laboratory Reports
☐ Operative Reports
☐ Pathology Reports
☐ Progress Notes
☐ X-ray Reports

For the following dates of service: From: ____________________ To: ____________________

PROTECTIVE OR SENSITIVE INFORMATION: I understand that certain information can not be released without specific authorization as required by State/Federal Law(s). By initialing, I authorize the release of the following protected or sensitive information:

___ Drug Abuse Diagnosis &/or Treatment ___ Alcoholism Diagnosis &/or Treatment ___ Mental Health &/or Treatment

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

______________________________ ____________________ ____________________
Signature of Patient or Representative | Relation to Patient | Date Signed

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

___ AIDS &/or HIV Test Results and Related Information Including High Risk Behavior Documentation ___ Genetic Testing

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

______________________________	______________________________	______________________________
Signature of Patient or Representative	Relation to Patient	Date Signed

Acknowledgement of Receipt of Notice

Sharon E. Wong, MD
10000 SE Main St. Ste 236 Portland, OR 97216

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed:____ Date:__________________________

Print Name:___________________________________ Telephone:_____________________

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of patient.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Name of Patient:____

For Office Use Only:

☐ Signed form received by:____________________________________ Date:__________________

☐ Acknowledgment refused:

Efforts to obtain:____

____

Reasons for refusal:____

____