

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physician you selected will review your health history and conduct an initial evaluation to determine whether the practice will accept you as a patient.

# To our patients:

In order to provide you with our full time and attention when you come for an appointment, we would like to ask you to be aware of the following guidelines.

### **Prescription Refills:**

- We are implementing a new state of the art e-prescribing system. This works best if you call your
  pharmacy directly for <u>any prescription refills</u>, even if you have no refills left. The pharmacy will contact
  us directly to get approval for a refill or new prescription.
- Please plan ahead as most local pharmacies request 2-3 business days to process prescription requests.
   Pharmacies will typically give you a 2-3 day supply of any non-narcotic medication if you run out without realizing it and you need time for the pharmacy to process the refill.
- For mail order prescriptions, please contact your pharmacy via their 800 number or website. Please be sure to contact your mail order pharmacy at least two weeks before you will need the refill. If it is necessary for us to complete forms for your mail order pharmacy, please give us three business days to complete the paperwork.
- Many drug plans will not cover brand name medications, or do so at a much higher cost. We are not
  always able to obtain prior authorizations for your medications. Generally, you can expect to receive
  generic medications or pay a higher cost if you prefer the brand name drugs.

#### Walk-in appointments:

 We almost always have same day appointments available for urgent needs. Please call ahead to schedule an appointment instead of arriving at our office and requesting to see the physician. Walk-ins impact our ability to see scheduled patients on time.

#### Test results:

- We will notify you regarding all lab results either at your appointment or by phone or mail.
- If you have not been contacted with your results two weeks after your appointment, please call our office to follow up.
- Pathology reports, pap smears, and bone density results may take up to four weeks. Please call our
  office if you have not been contacted after four weeks.
- Please note that if you request lab work prior to your annual appointment, your insurance may not pay for those labs.
- We are happy to provide you with your most recent lab or radiology reports. Please call ahead and we
  can have that ready for you at the front desk for pick up or mail results to you.



#### Copies of your medical record:

- If you would like a copy of your complete medical record, we will need a formal request from you, which must be completed in writing and signed by you or your authorized representative.
- Please allow 30 days for medical record requests. There is a processing charge to release records to yourself. There is no charge to release records from one doctor to another.

#### Co-pays:

• Our contracts with the insurance companies require us to collect your co-payment prior to your seeing the physicians. Please be prepared to pay this when you arrive for your appointment.

## Diagnostic testing:

- Your physician will generally have the report from any diagnostic testing 2 3 days following your test.
   The radiologist who reads the study will notify your physician if there are abnormal results that require immediate follow-up.
- Most CT scans require insurance pre-authorization if not emergent exam.
- MRI, PET, Nuclear Medicine, sleep studies, cardiac studies, and other diagnostic tests require insurance
  pre-authorization. You will be referred to outside facilities for these studies. We contact the imaging
  facility of your choice and the will contact you to schedule an appointment. If you have not been
  contacted after two weeks, please call our office to request assistance in getting your exam scheduled.

We appreciate you choosing Southern Oregon Internal Medicine for your health care needs.



## Southern Oregon Internal Medicine A Rogue Valley Physicians P.C. Clinic

2900 Doctors Park Drive, Suite 200 Medford, Oregon 97504 Phone: 541-282-2200

Fax: 541-282-2237

# Please fill in the following information completely (Please Print)

		TODA	I SDAIL _		
NAME		NIC	KNAME		
LAST	FIRST				
HAVE YOU EVER RECEIVED MEDIC					
IF YES, UNDER WHAT NA	ME?				
SOCIAL SECURITY #	DA	TE OF BIRTH/_	/ GI	ENDER	
PHYSICAL ADDRESS		6		0m + mr	710
	STREET ADDRESS	CITY		STATE	ZIP
MAILING ADDRESS IF DIFFERENT THAN ABOVE					
n bii bida i i i i i i i i i i i i i i i i i i	РО ВОХ	CITY		STATE	ZIP
RACE: LANGU	UAGE	HISPANIC OR LATI	NO [ ] YES [	] NO	
MARITAL STATUS (CIRCLE ONE)	SINGLE MARRIED	DIVORCED LEGALLY	SEPARATED	LIFE PARTNE	R WIDOWED
HOME PHONE	EMAIL		CELL PHO	ONE	
EMPLOYED: YES NO EMPLO	OYER	WOR	RK PHONE		
SPOUSE INFORMATION:					
NAME		HOME	PHONE:		
NAMELAST					
DATE OF BIRTH//	SOCIAL SECURIT	Y #			
EMPLOYER	W	ORK PHONE	C	CCUPATION_	
INSURANCE INFORMATIO					
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# Southern Oregon Internal Medicine 2900 Doctors Park Drive, Suite 200 | Medford, OR 97504

Phone: (541) 282-2227 | General Fax: (541) 282-2263

# **HEALTH HISTORY QUESTIONNAIRE**

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, Fir	rst, M.I.):		□M □F DOB:
Marital Status	: Single Partnered	☐ Married ☐ Separated	☐ Divorced ☐ Widowed
Previous or refe	erring doctor:		Date of Last physical exam:
Other doctors y	ou see:		How did you hear about us?
	DE	RSONAL HEALTH HIS	TODY
	PE	RSONAL HEALTH HIS	TORT
Childhood Illne	sses: 🛘 Measles 🚨 Mu	mps 🔲 Rubella 🔲 Chicke	npox Rheumatic Fever Polio
Immunizations	& Dates	☐ Tetanus	☐ Pneumonia
		☐ Hepatitis B	☐ Chickenpox
		☐ Hepatitis A	☐ MMR
		☐ Zostavax Shingles	Other
Health Mainten	ance that are recommended for	Colonoscopy Date:	Cardiac Stress Test Date:
screening and e	arly identification of common	☐ Have not	had test
chronic health p	roblems.	Triple Vessel Screening Date: (ultrasound aorta, carotid & legs)	Bone Density Date:
		☐ Have not	had test
List any medica	al problems that other doctors	s have diagnosed (you can circle o	common problems on the first line)
Diabetes Hype	rtension High-Cholesterol Os	teoporosis Heart-disease Thyro	id-disease Asthma Lung-Disease Anemia
Blackouts Bron	icnitis Cancer Gout Kidney	-disease Kidney-Stones Osteoar	thritis Rheumatoid-Arthritis Seizures Ulcers
N=2-1		NO. AND TO ANALYSIS OF THE PARTY OF THE PART	
Surgeries			
Year	Reason		Hospital
Have you ever	had a blood transfusion?	☐ Yes	□ No

List your prescribed dru	gs and over-the-counter di	rugs	and/or nutritional su	pplei	ments			
Medication Name	Strength				Frequency Tak	en		
		III 144 JH - 1						
Allergies to medications	I							
Name of Drug	Reaction `	You I	-lad			*		
							A DECEMBER OF THE PROPERTY OF	
	HEALTH HA	втт	S AND PERSO	NAI	SAFETY			
	NTAINED IN THIS QUESTIC	39/20/20	AIRE ARE OPTIONAL	AND	WILL BE KEPT STR	ICTLY	CONFIDE	NTIAL
Exercise	Sedentary (No exercis							
	Mild exercise (i.e., clin	_						
	Occasional vigorous						) minutes)	
DI.	Regular vigorous exe			ion, 4	4x/week for 30 minute	es)		
Diet	Are you following a diet?						☐ Yes	☐ No
	# of meals you eat in an a							
	Rank salt Intake	☐ Hi ☐ Medium		Low				
0 " :	Rank fat intake				Medium	O L		
Caffeine	☐ None		Coffee		☐ Tea ☐ (		Cola	
	# of cups/cans per day?							
Alcohol	Do you drink alcohol?						☐ Yes	☐ No
	If yes, what kind?	0.00000		Hov	w many drinks per w	eek?		
		cerned about the amount you drink?			☐ Yes	☐ No		
	Have you considered sto				☐ Yes	☐ No		
		er experienced blackouts?			☐ Yes	☐ No		
		e to "binge" drinking?			☐ Yes	☐ No		
Toboos	Do you drive after drinking?				☐ Yes	☐ No		
Tobacco	Do you use tobacco?						☐ Yes	☐ No
	☐ Cigarettes pks/day		☐ Chew - #/day		☐ Pipe - #/day		Cigars - #/	day
Devices	# of years							
Drugs	Do you currently use rec						☐ Yes	☐ No
Carr	Have you ever given you	_	street drugs with a n	eedl	e?		☐ Yes	☐ No
Sex	Are you sexually active?						☐ Yes	☐ No
	If yes, are you trying for a	-					☐ Yes	☐ No
	If not trying for a pregnar			thod				
	Any discomfort with inte	_					☐ Yes	□ No
	Do you have any concerns regarding sexual health you would like to discuss?				ss?	☐ Yes	□ No	

Personal S	Personal Safety Do you live alone?				☐ Yes	☐ No	
Do you have frequent falls?			☐ Yes	□ No			
Do you have vision or hearing loss?			☐ Yes	□ No			
Do you have an Advance Directive or Living Will?				☐ Yes	□ No		
	Would you like information on the preparation of these?				☐ Yes	□ No	
		Physical and/or mental abuse have b			ssues in this	103	- 110
	country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	□ No	
		Do you wear seatbelts when driving or riding in a car?				☐ Yes	□ No
		Have you ever had your driving licen	se suspended	?		☐ Yes	□ No
M.		FAMILY HEA	TTU UICT	ODV			
		FAMILI HEA	riu uisi	OKI			
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT	HEALTH PR	OBLEMS
Father			Children	□ M □ F			
Mother			Million - 2011/195-1979	□М			
Sibling	ОМ			□ F □ M	-		
Chamig	□ F			□F			
	□ M □ F			□ M □ F			
	ОМ		Grandmother				
	□ F □ M		Maternal Grandfather				
	Q F		Maternal				
	□ M □ F		Grandmother Paternal				
	□ M □ F		Grandfather Paternal				
			1 atemai				
		MENTAL	HEALTH				
Is stress a	major proble	m for y ou?				☐ Yes	☐ No
Do you fee	depressed?					☐ Yes	☐ No
Do you fee	l helpless or	hopeless?				☐ Yes	☐ No
Do you par	nic when stre	ssed?				☐ Yes	☐ No
Do you hav	ve problems v	vith eating or your appetite?				☐ Yes	☐ No
	frequently?					☐ Yes	□ No
Have you ever attempted suicide?						☐ Yes	□ No
Have you ever seriously thought about hurting yourself?					☐ Yes	□ No	
Do you have trouble sleeping?						☐ Yes	□ No
1022	ever been to a					☐ Yes	□ No
		thered by feeling down, depressed or h	ioneless?				
		thered by little interest or pleasure in d				☐ Yes	□ No
•		, manager of production in the	g timiga:			☐ Yes	☐ No
		EDUCATION AN	D OCCUP	ATION			
Where wer	e you born?						
	-	rel of education?					
		nt status? (what was your last job?)					
List some	of your favori	te hobbies:					

Age at onset of menstruation:         Date of last menstruation:         device of pregnancies         Number of live births           Heavy periods, irregularity, spotting, pain or broasteeding?           9 kg   0 kg		WOMEN ONLY			40
Heavy periods, irregularity, spotting, pain or discharge?	Age at onset of menstruation:	Date of last menstruation:	Period every _		days
Are you pregnant or braestfeeding?     Yes   No Have you had a D&C, Hysterectomy or Cesarean?     Yes   No Any urinary tract, bladder or kidney infections within the last year?   Yes   No Any blood in your urine?     Yes   No Any blood in your urine?     Yes   No Any problems with control of urination?     Yes   No No Any hot flashes or sweating at night?     Yes   No No Yes   No No Yes   Yes   No Yes   N	Number of pregnancies	Number of live births			
Have you had a D&C, Hysterectomy or Cesarean?   Yes   No Any urinary tract, bladder or kidney infections within the last year?   Yes   No Any blood in your urine?   Yes   No Any problems with control of urination?   Yes   No Any problems with control of urination?   Yes   No No Have you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?   Yes   No No Have you experienced any recent breast tenderness, lumps or nipple discharge?   Yes   No No Have you ever had an abnormal pap? If yes, when:   Yes   No No Have you ever had an abnormal pap? If yes, when:   Yes   No No Have you ever had an abnormal mammogram?   Yes   No No No Yes	Heavy periods, irregularity, spotting,	pain or discharge?		☐ Yes	☐ No
Any urinary tract, bladder or kidney infections within the last year?           Yes   No           Any blood in your urine?           Yes   No           Any problems with control of urination?           Yes   No           Any hot flashes or sweating at night?           Yes   No           Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?           Yes   No           Have you experienced any recent breast tenderness, lumps or nipple discharge?           Yes   No           Date of your last pap and rectal exam.           Yes   No           Have you ever had an abnormal pap? If yes, when:   Date of your last mammogram.           Yes   No           MEN ONLY           MEN ONLY           Do you usually get up to urinate during the night? If yes, # of times:   Yes   No           Yes   No           Any blood in your urine?           Yes   No           No           Any blood in your urined?           Yes   No           Yes   No           Have you had any kidney, bladder or prostate infections within the last 12 months?           Yes   No           No           Bave you had any kidney, bladder or prostate infections within the last 12 months?           Yes   No           No           Do you have any problems emptying your bladder completely?           Yes   No           No           No           No           Yes   No           No	Are you pregnant or breastfeeding?			☐ Yes	□ No
Any blood in your urine?   Yes   No Any problems with control of urination?   Yes   No Any problems with control of urination?   Yes   No Any hot flashes or sweating at night?   Yes   No Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?   Yes   No Have you experienced any recent breast tenderness, lumps or nipple discharge?   Yes   No Date of your last pap and rectal exam.  Have you ever had an abnormal pap? If yes, when:   No Date of your last mammogram.  Have you ever had an abnormal mammogram?   Yes   No Any blood in your urinate during the night? If yes, # of times:   Yes   No Any blood in your urine?   Yes   No Do you seal burning discharge from penls?   Yes   No Has the force of your urination decreased?   Yes   No Have you had any kidney, bladder or prostate infections within the last 12 months?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Have yot had any kidney, bladder or prostate infections within the last 12 months?   Yes   No Any difficulty with erection or ejaculation?  Any testicle pain or swelling?   Yes   No Defact of last prostate and rectal exam.  OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.   Skin   Recent changes in:   Skin   Recent changes in:   Head/Neck   Back   Weight   Head/Neck   Back   Weight   Head/Neck   Recent changes in:   He	Have you had a D&C, Hysterectomy of	or Cesarean?		☐ Yes	☐ No
Any problems with control of urination?         □ Yes         □ No           Any hot flashes or sweating at night?         □ No         □ No         □ No           Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?         □ Yes         □ No           Have you experienced any recent breast tenderness, lumps or nipple discharge?         □ Yes         □ No           Date of your last pap and rectal exam.         □ Vers         □ No           Have you ever had an abnormal pap? **If yes, when: □ □ Vers         □ Vers         □ Vers           MEN ONLY           MEN ONLY           Do you usually get up to urinate during the night? **If yes, **If times: □ □ Yes         □ No         □ No           Any blood in your urine?         □ Yes         □ No           Do you feel burning discharge from penis?         □ No         □ No           Has the force of your urination decreased?         □ Yes         □ No           Have you had any kidney, bladder or prostate infections within the last 12 months?         □ Yes         □ No           Do you have any problems emptying your bladder completely?         □ Yes         □ No           Any testicle pain or swelling?         □ Yes         □ No           Date of last prostate and rectal exam.         □ Check if you have, or have had, any symptoms in th	Any urinary tract, bladder or kidney i	nfections within the last year?		☐ Yes	☐ No
Any hot flashes or sweating at night?     Yes   No Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?   Yes   No Have you experienced any recent breast tenderness, lumps or nipple discharge?   No Date of your last pap and rectal exam.  Have you ever had an abnormal pap? If yes, when:   Date of your last mammogram.  Have you ever had an abnormal mammogram?   Yes   No Any go you usually get up to urinate during the night? If yes, # of times:   Yes   No Any blood in your urine?   Yes   No Do you feel burning discharge from penis?   Yes   No Has the force of your urination decreased?   Yes   No Have you had any kidney, bladder or prostate infections within the last 12 months?   Yes   No Any difficulty with erection or ejaculation?   Yes   No Any difficulty with erection or ejaculation?   Yes   No Date of last prostate and rectal exam.  OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.   Skin   Chest/Heart   Recent changes in:   Head/Neck   Back   Weight   Head/Neck   Back   Weig	Any blood in your urine?			☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around your period?	Any problems with control of urination	on?		☐ Yes	☐ No
Have you experienced any recent breast tenderness, lumps or nipple discharge?	Any hot flashes or sweating at night?	?		☐ Yes	☐ No
Date of your last pap and rectal exam.  Have you ever had an abnormal pap? If yes, when:  Date of your last mammogram.  Have you ever had an abnormal mammogram?    MEN ONLY    MEN ONLY   Yes   No   No   No   No   No   No   No   N	Do you have menstrual tension, pain	, bloating, irritability, or other symptoms at or ar	ound your period?	☐ Yes	□ No
Have you ever had an abnormal pap? If yes, when:  Date of your last mammogram.  Have you ever had an abnormal mammogram?    MEN ONLY    MEN ONLY	Have you experienced any recent bre	east tenderness, lumps or nipple discharge?		☐ Yes	□ No
Date of your last mammogram?    Have you ever had an abnormal mammogram?   MEN ONLY    MEN ONLY	Date of your last pap and rectal exam	1.		•	
MEN ONLY    Do you usually get up to urinate during the night? If yes, # of times:   Yes   No Any blood in your urine?   Yes   No Do you feel burning discharge from penis?   Yes   No Has the force of your urination decreased?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Any difficulty with erection or ejaculation?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems empty yes   No Do you have any problems   Yes	Have you ever had an abnormal pap?	? If yes, when:			
MEN ONLY  Do you usually get up to urinate during the night? If yes, # of times:   Yes   No Any blood in your urine?   Yes   No Do you feel burning discharge from penis?   Yes   No Has the force of your urination decreased?   Yes   No Do you had any kidney, bladder or prostate infections within the last 12 months?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Any difficulty with erection or ejaculation?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Do you have any problems emptying your bladder on your problems empty yes   No Do you have any problems   Yes   No Do you	Date of your last mammogram.				
Do you usually get up to urinate during the night? If yes, # of times:   Yes   No Any blood in your urine?   Yes   No Do you feel burning discharge from penis?   Yes   No Has the force of your urination decreased?   Yes   No Have you had any kidney, bladder or prostate infections within the last 12 months?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Any difficulty with erection or ejaculation? Any testicle pain or swelling?   OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.   Skin   Chest/Heart   Recent changes in:     Head/Neck   Back   Weight     Ears   Intestinal   Energy level     Nose   Bladder   Ability to sleep     Throat   Bowel   Other pain/discomfort	Have you ever had an abnormal mam	nmogram?			
Do you usually get up to urinate during the night? If yes, # of times:   Yes   No Any blood in your urine?   Yes   No Do you feel burning discharge from penis?   Yes   No Has the force of your urination decreased?   Yes   No Have you had any kidney, bladder or prostate infections within the last 12 months?   Yes   No Do you have any problems emptying your bladder completely?   Yes   No Any difficulty with erection or ejaculation? Any testicle pain or swelling?   OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.   Skin   Chest/Heart   Recent changes in:     Head/Neck   Back   Weight     Ears   Intestinal   Energy level     Nose   Bladder   Ability to sleep     Throat   Bowel   Other pain/discomfort		MEN ONLY			
Any blood in your urine?  Do you feel burning discharge from penis?  Has the force of your urination decreased?  Have you had any kidney, bladder or prostate infections within the last 12 months?  Do you have any problems emptying your bladder completely?  Any difficulty with erection or ejaculation?  Any testicle pain or swelling?  Date of last prostate and rectal exam.  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Skin  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Head/Neck  Back  Weight  Head/Neck  Back  Head/Neck  Back  Head/Neck  Back  Other pain/discomfort				T 5	T
Do you feel burning discharge from penis?					-
Has the force of your urination decreased?  Have you had any kidney, bladder or prostate infections within the last 12 months?  Do you have any problems emptying your bladder completely?  Any difficulty with erection or ejaculation?  Any testicle pain or swelling?  Date of last prostate and rectal exam.  OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Skin  Chest/Heart  Recent changes in:  Head/Neck  Back  Weight  Ears  Intestinal  Energy level  Nose  Bladder  Bowel  Other pain/discomfort					
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Any difficulty with erection or ejaculation?  Any testicle pain or swelling?  Date of last prostate and rectal exam.  OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Skin Chest/Heart Recent changes in: Head/Neck Back Weight Ears Intestinal Energy level Nose Bladder Ability to sleep Throat Bowel Other pain/discomfort					
Any testicle pain or swelling?  Date of last prostate and rectal exam.  OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Skin				☐ Yes	□ No
Date of last prostate and rectal exam.  OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Skin		ation?			
OTHER PROBLEMS  Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Chest/Heart   Recent changes in:  Head/Neck   Back   Weight  Ears   Intestinal   Energy level  Nose   Bladder   Ability to sleep  Throat   Bowel   Other pain/discomfort					
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Chest/Heart Recent changes in:  Head/Neck Back Weight  Ears Intestinal Energy level  Nose Bladder Ability to sleep  Throat Bowel Other pain/discomfort	Date of last prostate and rectal exam.	•			
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.  Chest/Heart Recent changes in:  Head/Neck Back Weight  Ears Intestinal Energy level  Nose Bladder Ability to sleep  Throat Bowel Other pain/discomfort		OTHER PROPIEMS			
□ Skin □ Chest/Heart □ Recent changes in:   □ Head/Neck □ Back □ Weight   □ Ears □ Intestinal □ Energy level   □ Nose □ Bladder □ Ability to sleep   □ Throat □ Bowel □ Other pain/discomfort					
□ Head/Neck       □ Back       □ Weight         □ Ears       □ Intestinal       □ Energy level         □ Nose       □ Bladder       □ Ability to sleep         □ Throat       □ Bowel       □ Other pain/discomfort					503
□ Ears □ Intestinal □ Energy level □ Nose □ Bladder □ Ability to sleep □ Throat □ Bowel □ Other pain/discomfort	Skin	☐ Chest/Heart	☐ Recent change	s in:	
□ Nose □ Bladder □ Ability to sleep □ Throat □ Bowel □ Other pain/discomfort	☐ Head/Neck	□ Back	□ Weight		
□ Throat □ Bowel □ Other pain/discomfort	☐ Ears	□ Intestinal	☐ Energy level		
a other pain/disconnort	□ Nose	□ Bladder	☐ Ability to sleep		
☐ Lungs ☐ Circulation	☐ Throat	□ Bowel	☐ Other pain/disc	comfort	
	☐ Lungs	☐ Circulation			



# **Financial Policy**

Patient Name:	Date of Birth:	

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we require you to read and sign prior to your visit with us. Please be sure to complete both pages.

#### REGARDING YOUR INSURANCE

It is not possible for a medical practice to become familiar with the details of every health insurance plan it encounters. It is the responsibility of the patient to be aware of what is covered and what is not covered by your insurance, and how much the patient responsibility for services will be. We will submit insurance claims as a courtesy to our patients with insurance, and will help you in every way possible to obtain your maximum insurance benefits. However, you are responsible for our charges. We ask that you pay any deductible, co-pay and balance owed at the time of service. Please remember that we can only estimate the amount to be paid by an insurance company as they make payments based on their fee schedule. Their fee schedules may differ from our charges. While we attempt to help you in every way possible to obtain your maximum allowable insurance benefits, the insurance contract is between you and your insurance company and does not replace your responsibility for your account. If your insurance company has not paid your claim within 45 days, we will ask you to pay the balance in full. We will not be calling your insurance prior to your visit to verify your coverage.

#### SECONDARY INSURANCE

Having more than one insurer does not necessarily mean that your services are covered at 100%. We may bill your secondary carrier as a courtesy. You are responsible for any balance after insurance(s) has cleared.

#### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Continued ...

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#### FOR PATIENTS WITHOUT INSURANCE

We ask that our patients that do not have insurance pay at least ½ of their charges at the time of service. The remainder of this balance must be paid in 2 equal monthly payments. Special arrangements may be made with the advance approval of the billing department. Please let the receptionist know if you need to speak to our billing staff.

#### OREGON HEALTH PLAN PATIENTS

If you are an Oregon Health Plan/Medical Card patient, we require that you show your current medical card before each visit and that you are currently assigned to the appropriate physician. We will re-schedule your appointment if you fail to comply with this policy and do not present with your current card. We are unable to call your insurance prior to your visit to verify your coverage.

#### SERVICE CHARGES

A fee of \$25.00 will be assessed to your account for any check returned due to non-sufficient funds. A fee of \$20.00 may be assessed to your account for a missed appointment.

# WE ACCEPT PERSONAL CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CASH

Thank you for your attention to our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to the terms of this Policy. In addition, I authorize Southern Oregon Internal Medicine to release any medical information necessary to process a claim. I hereby assign payment directly to Rogue Valley Physicians, PC all payments due from my insurance company. I understand that I am financially responsible for the charges and should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient.

Patient (or Legal Guardian) Signature	Date

#### Southern Oregon Internal Medicine

Signature of patient or legally authorized representative

2900 Doctors Park Drive Medford, OR 97504



Authorization to Release Medical Information Patient: Birth date: I consent to the release of Medical Information (records): To: From: (Physician, Clinic, or Person) Dr. Christopher Murphy 2900 Doctors Park Drive Medford, OR 97504 Phone: (541) 282-2200 Fax: (541) 282-2266 **Information to be released:** Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, X-ray & Laboratory Reports. From Date: \_\_\_\_\_\_ To Date: \_\_\_\_\_ X-ray reports only. Date(s): Laboratory and Pathology reports only. Date(s): Other tests or studies (list type of test/study and date performed): Other (specify): In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record. \*(Initial if release is authorized) Drug and alcohol abuse Information related to diagnosis/treatment of HIV. Please note that a separate release is required for Behavioral Health Information. **Purpose of Disclosure:** This authorization is valid for six months after the date of signature. The authorization may be revoked any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

Date

## SOUTHERN OREGON INTERNAL MEDICINE



# **Telephone Disclosure form**

Patient Name (please print)		DOB
Welcome to Southern Oregon Internal Medic information in a way that is acceptable to yo you have a special request, be sure to let you	u. We appreciate your takin	•
It is okay to leave information on my answeri	ng machine: Yes	No
Please indicate which medical information y	ou authorize to be disclosed	I via the telephone from our office:
Appointments Lab/Pathology Results EKG Results X-ray Results Authorization for verbal disclosure of my p	ALL OF THE ABOVE	ole information alts (men may also need this)
Name:		_
Phone #:		
Name:	Relationship:	
Phone #:		
(initial) Do not disclose my health	information to anyone.	
Signature	Date	Relationship
This authorization may be revoked by giving we Such notice will be effective immediately up This consent will be valid for up to one (1) year	on receipt by Southern Oreg	_
Date of consent:	_ Date con	sent expires:
I recognize that the information disclosed malaws (i.e., Drug/Alcohol Abuse, Mental Healt information. Initial each one that applies:	= = = = = = = = = = = = = = = = = = =	-
HIV/AIDS results	Mental Health	Drug/Alcohol Abuse
Signature		 Date

Thank you. If you need to contact our office, remember that we may be busy serving other patients, but we

will make every effort to return calls within 24 business hours.