**Grants Pass Clinic, L.L.P.**
495 SW Ramsey Avenue • Grants Pass, Oregon 97527 • Phone 541-476-6644

Welcome to the Grants Pass Clinic. Our goal is to provide you high quality health care with compassion, integrity, and professionalism. We are pleased you have chosen us for your health care needs and hope to make your experience here as positive as possible.

For your first appointment, we request that you **arrive at least 20 minutes early** to complete the check-in process. Enclosed you will find our Acknowledgement and Consent for our Notice of Privacy Practices and the Financial Policy. These are included to provide time for you to read and review to ensure your understanding before signing the forms.

In addition, we have enclosed a copy of the Grants Pass Clinic Directory that contains useful information regarding some of our policies. Hopefully this will assist you when you have to call for an appointment, refill a medication, or address an insurance question. By accessing our patient portal or calling the numbers provided, you should decrease any hold time and complete your inquiry in a timely fashion.

For your first appointment, please bring with you the following items:

- Current Insurance card or proof of insurance (including Medicare if applicable)
- Driver's license or photo ID
  *If your photo ID does not show your current street address or if a PO Box is listed, please bring a utility bill or other correspondence showing current street address.*
- Co-pay (due and payable before each office visit)
- Enclosed Acknowledgement and Consent Form/Financial Policies
- Enclosed Patient Registration
- Enclosed Adult Annual Visit Sheet
- Enclosed FollowMyHealth Patient Portal information

Please be aware that according to HIPAA guidelines we are only able to discuss your medical issues with you or people you have designated in writing. If you would like to designate someone other than yourself, complete the Designation of Personal Representative form and return it to our Information desk.

Thank you,
Grants Pass Clinic

Provider Name _____

Appointment Date _____ Time _____

Grants Pass Clinic, L.L.P.

# Financial Policies

Thank you for choosing Grants Pass Clinic for your healthcare needs. To ensure we can provide high-quality care, we ask that patients review and understand our financial policies. Working together helps ensure accurate billing and timely payment for services rendered.

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

Patients are required to read and sign this agreement prior to receiving treatment.

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## Payment Options

We accept **cash, check, Visa, MasterCard, and Discover**. A **$25.00 fee** will be charged for all returned checks.

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## Insurance

It is the patient's responsibility to verify insurance benefits directly with their insurance carrier. Please note that we are unable to submit claims to certain non-participating insurance plans.

We expect payment from insurance carriers within **90 days**. Any remaining balance after that time may be transferred to the patient's account and will be due in full.

Patients are responsible for providing accurate and current insurance information. If a claim is denied due to invalid information, failure to report insurance changes, or timely filing issues, the patient will be responsible for the full balance.

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## Self-Pay Patients

Self-pay patients include individuals without insurance or those whose insurance plans we do not participate with. A **minimum pre-payment of $150** is required prior to treatment.

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## Copayments and Non-Covered Services

Copayments are due at **check-in**. Any services not covered by insurance must be paid **at the time of service**.

**Other Services**

Some services and supplies are not available on a credit basis and may require partial or full payment in advance. If applicable, you will be provided with a separate payment policy.

**Authorizations and Referrals for Out-of-Network Plans**

If your out-of-network insurance plan requires a referral or prior authorization, it is the patient's responsibility to ensure the proper authorization has been obtained. Services provided without required authorization may be denied by insurance, making the patient responsible for all charges.

**Payment Arrangements**

Payment plans may be available with approval from the Billing Office. The minimum monthly payment is **10% of the total balance** or **$25.00**, whichever is greater. Monthly payments are required in addition to any copayments for future visits.

We partner with **Resolution Resource** to assist with payment plans. Accounts not kept in good standing may be sent to an external collection agency. If an account is placed in collections, Grants Pass Clinic reserves the right to dismiss the patient and any related family members from the practice.

**Acknowledgment and Assignment of Benefits**

I acknowledge full financial responsibility for services provided by Grants Pass Clinic. I confirm that I have read and understand these financial policies. I authorize my insurance benefits to be paid directly to Grants Pass Clinic, LLP. I understand that if my account goes into default, I am responsible for all collection costs, including court costs and reasonable attorney fees. I authorize Grants Pass Clinic and my insurance company to release any information necessary for the processing of my claims.

_____ _____

Patient's Name (please print) Date of Birth

_____

Name of Responsible Party (please print)

_____ _____

Signature of Responsible Party Date

# 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,** L.L.P.
495 SW Ramsey Avenue , Grants Pass, OR 97527, 541-476-6644

# PATIENT REGISTRATION

## PATIENT INFORMATION

PATIENT Last Name First Name Middle Initial DOB Sex

Physical Address City State Zip Home Number Mobile Number

Mailing Address City State Zip

Personal Email Address SS#

Employer Work Number

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SPOUSE Last Name First Name Middle Initial DOB Sex

Physical Address City State Zip Home Number Mobile Number

Mailing Address City State Zip

Employer Work Number SS#

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Guarantor ☐ Patient ☐ Spouse (Select primary person to receive billing statement)

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## INSURANCE INFORMATION

Primary Insurance Carrier Member ID # Group # Group Name

Subscriber ☐ Patient ☐ Spouse ☐ Other: List name, DOB, Sex _____

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Secondary Insurance Carrier Member ID # Group # Group Name

Subscriber ☐ Patient ☐ Spouse ☐ Other: List name, DOB, Sex _____

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

*Signature* *Date*

# Adult Annual Visit

**MRN**_____ **Today's Date** _____

**Name**_____ **Date of Birth**_____

Are you seen at the VA? Yes No

List anyone else involved with your care including other medical providers:

**SOCIAL HISTORY:**

Marital Status: _____ Do you have an Advance Directive? YES/NO

Are you currently employed? YES / NO -- Occupation: _____

Describe your current physical activities: _____

Describe your current diet: _____

**TOBACCO USE:**

Have you smoked tobacco within the last 30 days?.....YES/NO

Never a Smoker: _____

Former Smoker: _____ How Many Packs Per Day? _____ How Many Years? _____

Current Smoker: _____ How Many Packs Per Day? _____ How Many Years? _____

Interest in Quitting? YES / NO

**ALCOHOL USE:**

How many drinks per week?

**Alcohol:** One drink = 12 oz. beer 5 oz. wine 1.5 oz. liquor (one shot)

| | None | 1 or More |
|---|---|---|
| MEN: How many times in the past year have you had 5 or more drinks in a day? | | |
| WOMEN: How many times in the past year have you had 4 or more drinks in a day? | | |

**RECREATIONAL DRUG USE:**

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

| | None | 1 or more |
|---|---|---|
| How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? | | |

**DEPRESSION SCREENING:**

Over the last 2 weeks, how often have you been bothered by any of the following:

| | Not At All | Several Days | More Than Half The Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things: | | | | |
| 2. Feeling down, depressed or hopeless: | | | | |

**ALLERGIES:** (Please list any food or drug allergies)

_____

**CURRENT MEDICATIONS:** (Please include supplements and non-prescription medications)

| | |
|---|---|
| 1. | 9. |
| 2. | 10. |
| 3. | 11. |
| 4. | 12. |
| 5. | 13. |
| 6. | 14. |
| 7. | 15. |
| 8. | 16. |

**FAMILY HISTORY:**

Have your parents, brothers, sisters or children ever been treated for (circle yes or no):

Cancer…… YES / NO Who? _____ High Blood Pressure…… YES / NO Who?_____

Neurological Disorders…….. .YES / NO Who? _____ Heart Disease…… YES / NO Who?_____

Diabetes……....YES / NO Who? _____ Blood Disease ……...…… YES / NO Who?_____

**HISTORY OF MEDICAL CARE** – to the best of your knowledge please provide the date and provider for the screenings listed below:

| | | When? | Where? |
|---|---|---|---|
| **Colon Cancer Screening** | What type of screening?<br>FIT / FOB / colonoscopy | | |
| **Bone Density Screening** | | | |
| **Eye Exam** | | | |
| **Mammogram** | *****For Women***** | | |
| **Pap Smear/Cervical Cancer Screening** | Was an HPV screening done?<br>Y / N | | |
| If you are 50 years old or under: Would you like to become pregnant in the next year? | Yes No | Current method of birth control: | Last menstrual period: |

**PAST MEDICAL HISTORY:**

Have YOU ever been treated for (circle yes or no):

Cancer…… YES / NO
Neurological Disorders……..…. YES / NO
Heart Disease……... YES / NO
Muscular Disorder…….. YES / NO
Glaucoma……... YES / NO
High Blood Pressure…… YES / NO
Hay Fever or Asthma……..….. YES / NO
Blood Disease……...…….. YES / NO
Kidney Trouble……..…. YES / NO
Diabetes……..…….. YES / NO

**PAST SURGICAL HISTORY:** (Please list all major surgeries)

_____

_____

*****Provider Use Only*****

REVIEWED BY: _____DATE:_____

# NEW PATIENT:
# REVIEW OF SYSTEMS

**MRN**_____ **Today's Date** _____

**Name** _____ **Date of Birth** _____

***(Please check all that apply):***

**CONSTITUTIONAL:**
__ Fever
__ Feeling Poorly
__ Recent Weight Gain
__ Chills
__ Feeling Tired
__ Recent Weight Loss

**EYES:**
__ Eye Pain
__ Eyesight Problems
__ Dryness of the Eyes
__ Red Eyes
__ Discharge from the Eyes
__ Itching of the Eyes

**ENT:**
__ Earache
__ Nosebleeds
__ Sore Throat
__ Hearing Loss
__ Nasal Discharge
__ Hoarseness

**CARDIOVASCULAR:**
__ Chest Pain
__ Fast Heart Rate
__ Intermittent Leg Swelling
__ Palpitations
__ Slow Heart Rate

**RESPIRATORY:**
__ Shortness of Breath
__ Shortness of Breath w/Exertion
__ Cough
__ Trouble Breathing
__ Wheezing
__ Trouble Breathing w/Sleep

**GASTROINTESTINAL:**
__ Abdominal Pain
__ Constipation
__ Heartburn
__ Vomiting
__ Nausea
__ Diarrhea
__ Bright Red Blood Per Rectum
__ Difficulty Swallowing

**GENITOURINARY:**
__ Difficulty Urinating
__ Vaginal Discharge
__ Incontinence
__ Unexplained Vaginal Bleeding
__ Urinary Frequency
__ Feelings of Urgency

**MUSCULOSKELETAL:**
__ Joint Pain
__ Joint Swelling
__ Limb Pain
__ Joint Stiffness
__ Back Pain

**INTEGUMENTARY:**
__ Skin Lesion
__ Itchy Skin
__ Breast Pain
__ Breast Lump
__ Rash
__ Dry Skin

**NEUROLOGIC:**
__ Confusion
__ Dizziness
__ Limb Weakness
__ Fainting
__ Difficulty Walking
__ Numbness
__ Headache
__ Memory Lapse or Loss

**PSYCHIATRIC:**
__ Suicidal
__ Anxiety
__ Personality Change
__ Sleep Disturbances
__ Depression
__ Emotional Problems

**ENDOCRINE:**
__ Feelings of Weakness
__ Hot Flashes
__ Always Thirsty
__ Frequent Urination
__ Intolerance to Cold
__ Intolerance to Heat

**HEMATOLOGIC / LYMPHATIC:**
__ Easy Bleeding
__ Swollen Glands
__ Easy Bruising
__ Swollen Glands in Neck

**ALLERGY / IMMUNOLOGIC:**
__ History of Asthma
__ Hives
__ Eczema
__ Hay Fever

**OTHER:**
_____
_____
_____
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_____
_____
_____
_____

**Reviewing Physician:** _____ **Date:**_____

MRN _____

Grants Pass Clinic, LLP.
495 SW Ramsey Ave
Grants Pass, OR 97527
(541) 476-6644 Fax (541) 472-5673

# AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

**THIS AUTHORIZATION MUST BE WRITTEN, DATED, AND SIGNED BY THE PATIENT OR BY A PERSON AUTHORIZED BY LAW TO GIVE THIS AUTHORIZATION**

Mailed_____
Faxed _____
Date_____
Staff Initials_____

**A.** I _____ _____ _____
Patient Name Date of Birth Phone

hereby authorize a copy of my Medical Records to be released:

**TO:** *Provider*_____
*Address* _____
_____
*Phone* _____
*Fax* _____

**FROM:** *Provider* _____
*Address* _____
_____
*Phone* _____
*Fax* _____

Purpose of Disclosure: Changing Provider/Clinic ____ Other_____

**B.** By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist: ***(Must be initialed. Do not check.)***

_____ Pertinent 3-yr Medical Records _____ Diagnostic imaging reports _____ Laboratory reports
_____ Physical therapy records _____ Pathology reports
_____ Specific Request/other _____

**C.** If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. **I understand and agree that this information will be disclosed if I place my initials in the space behind "Yes".**

Yes_____release **OR** No_____do not release HIV/AIDS information
Yes_____release **OR** No_____do not release Mental health information
Yes_____release **OR** No_____do not release Alcohol/chemical dependency diagnosis, treatment, or referral information
Yes_____release **OR** No_____do not release Genetic testing information
Yes_____release **OR** No_____ do not release Sexually transmitted disease information

***I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.***

**PATIENT INFORMATION** You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Grants Pass Clinic Records Release Dept., 495 SW Ramsey Ave., Grants Pass, OR 97527 and state you are revoking this authorization.

***This authorization DISCONTINUES my care through Grants Pass Clinic.*** Yes_____ No_____

**D.** I have read this authorization and understand it. Unless revoked, this authorization will expire 180 days from the date of signing.

Signature_____ Date _____
Patient or person authorized by law

Printed Name _____
If signature above is not the patient, please describe person's authority to act on patient's behalf (below):

*****Although 30 days are allowed to process requests, we will make every effort to expedite the process*****

# PROCESSING FEES

If your records are being sent to another treating physician/provider, we will send these as a courtesy. If you are requesting a copy of your records for your own use, there is a copying and processing fee of $15.00 for the first 10 pages and $.25 for each additional page.

I agree that these fees are due and payable upon receipt of my records.

_____
Name

_____
Date

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

MRN_____

# DESIGNATION OF PERSONAL REPRESENTATIVE

- Federal law says that Grants Pass Clinic, LLP cannot share your health information without your permission except in certain situations. (See our Notice of Privacy Practices). If you sign this form, you are giving us permission to share your health information with the person(s) you name as your Personal Representative.
- You can name more than one person as your Personal Representative.
- This Personal Representative Designation will last until you tell the Grants Pass Clinic, LLP you do not want it to treat the person(s) you name below as your Personal Representative any longer.
- **Right to Revoke:** If you decide you do not want the person(s) you name below to act as your Personal Representative any longer, you have the right to revoke this designation. Any revocation can only apply on and after the date that we receive your Revocation. We cannot cancel any disclosures made before we received the Revocation.
- Designation of a Personal Representative **does not** take the place of a Power of Attorney. **It does not permit release of my medical records**.

PATIENT NAME_____DATE OF BIRTH_____

First Designee I name the following person to act as my personal representative: Phone_____

Designee Name: _____ Relationship to Patient: _____

I authorize the Designee to have the following specific information in order to participate in my care (check each box that applies):

☐Appointment information ☐All healthcare information to coordinate care
☐Billing information ☐Other: _____

Alternate Designee I name the following person to act as my personal representative: Phone_____

Designee Name: _____ Relationship to Patient: _____

I authorize the Designee to have the following specific information in order to participate in my care (check each box that applies):

☐Appointment information ☐All healthcare information to coordinate care
☐Billing information ☐Other: _____

Alternate Designee I name the following person to act as my personal representative: Phone_____

Designee Name: _____ Relationship to Patient: _____

I authorize the Designee to have the following specific information in order to participate in my care (check each box that applies):

☐Appointment information ☐All healthcare information to coordinate care
☐Billing information ☐Other: _____

I have had full opportunity to read and consider the contents of this designation, and I confirm that the contents are consistent with my direction to Grants Pass Clinic, LLP. I understand that by signing this form, I am confirming my designation of a personal representative and that Grants Pass Clinic, LLP may use and/or disclose my protected health information to the person(s) named on this form. This form shall be in effect until I revoke the Personal Representative Designation by signing the Revocation, below, and give it to Grants Pass Clinic, LLP.

Print Name_____

Signature_____ Date_____

**REVOCATION:**

I no longer want the person named above to act as my Personal Representative.

Signature_____ Date_____

Rev 3/2025

**GRANTS PASS CLINIC, L.L.P**
**495 SW Ramsey Ave.**
**Grants Pass, OR 97527**

# Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants. With the exception of anonymous or coded research use of your health information or biological samples for genetic research requires your specific written consent.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

**If you want to allow** your health information and biological sample to be available for anonymous or coded genetic research, **you don't have to do anything.** If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

**If you want to decline** to have your health information and biological sample available for anonymous or coded genetic research, **you must tell your health care provider** by completing this form and giving or mailing it to your health care provider at the above address ATTN: Patient Services.

Your decision is effective on the date your health care provider processes this form.

If you have any questions or concerns about this notice, please contact the Oregon Genetics Program at (971) 673-0271 or www.oregongenetics.org.

No matter what you decide now, you can always change your mind later. If you change your mind, notify your health care provider in writing. Your new decision will apply only to health information or biological samples collected after your health care provider receives written notice of your new decision.

_____ I decline to have my health information and biological samples available for anonymous or coded genetic research.

_____ _____
**Patient Name** (please print) Date of Birth

_____ _____
Signature of patient or person authorized by law Date Signed

# Grants Pass Clinic, L.L.P.

495 SW Ramsey Avenue
Grants Pass, OR 97527

**541-476-6644**

www.grantspassclinic.com

## DEPARTMENTS

- Internal Medicine
- Family Practice
- Pediatrics
- Podiatric Medicine and Surgery

## ON-SITE SERVICES

- Laboratory
- Radiology
- EKGs
- Pulmonary Function
- Treadmill
- Holter Monitor
- Behavioral Health Counselor
- Substance Abuse Counselor
- Spirometry

## PROGRAMS

- Anticoagulation Clinic
- Flu Shot Clinic
- Weight Loss Clinic

## PROVIDERS
## Board Certified

### INTERNAL MEDICINE

J. Spencer Countiss, MD
Haitham B. Haddad, MD
Nina Lara, FNP-C
Benjamin L. Moss, PA-C
Markus H. A. Opel, MD
Andrew S. Pitzak, DO
Marcel Wiggers, MD

### FAMILY MEDICINE

Allie B. Brieske, PA-C
Jeremy J. Hitchcock, MD
Matthew B. Mote, DO
Timothy E. Roberts, MD
Raychel Rojas, FNP-C
John D. Wilson, MD

### PEDIATRICS and Adolescent Medicine

Neil A. Phillips, DO
Erin Clark, CPNP

### PODIATRIC MEDICINE *and* SURGERY

Sean P. Dunn, DPM, FACFAS
Joseph M. Vella, DPM, FACFAS

*Please see other side for Clinic Information*

## HOURS of OPERATION

**Monday - Friday 8:00 a.m. to 5:00 p.m.**

| | | |
|---|---|---|
| Laboratory | Monday—Friday | 7:30 a.m.—5:00 p.m. |
| X-Ray | Monday—Friday | 8:30 a.m.—5:00 p.m. |

## APPOINTMENT SCHEDULING

541-476-6644

**After Hours 541-476-6644**

*The Answering Service will direct your call.*

## Main Clinic Number

**541-476-6644**

## Other Helpful Numbers

Business Office…….. 541-472-5580
*(Referrals - Credit - Insurance - Billing - Medicare)*

Patient Care (MA/Nurses)… 541-476-6644

Lab Appointments (Call your provider's office)

Anticoagulation Clinic……541-472-5519

Patient Services…….541-472-5515

FollowMyHealth……..……...541-472-5566

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**TREATMENTS PROVIDED FOR OUR PATIENTS** *In addition to visits for regular medical care we treat:*

- Acute Illnesses
- Injuries *
- Minor Surgeries

*(except for motor vehicle accidents and workers compensation )

**PROVIDERS ABSENCE** If your provider is unavailable, **someone from that department will respond.** If your question or concern can wait, your provider's office will respond upon his or her return. If you cannot wait, please call and tell the receptionist; an on-call provider's office will respond to your needs.

**TEST RESULTS** Access to your results are available on our patient portal. Some providers may notify you by mail or phone if no follow-up appointment is scheduled. However, if you need assistance, send a secured message on our patient portal or call your providers assistant and we will contact you after reviewing your test results. Please allow adequate time (approximately one week) for the tests to be processed.

**PRESCRIPTION REFILLS** Request refills on our patient portal or call your pharmacy. All refills are sent electronically to pharmacies so they will electronically contact us; this applies to local or mail order pharmacies. Our staff requires the electronic request and *will not be able to refill from a phone request or if requested in person.*

**MEDICAL RECORDS** If you need your medical records to be sent (relocating, etc.) call 541-476-6644 or stop by the Information Desk and we will assist you. Please allow at least 30 days for your records to become available. **For referral appointments:** Your records will be available prior to your scheduled appointment.

**HANDICAPPED ACCESSIBILITY** We accommodate people with special needs. Handicapped accessible restrooms are located on each floor. Ask at the Information Desk for directions or assistance.

**INSURANCE** We bill most insurance companies. You can call our Business Office at 541-472-5580 for more information. If your insurance company requires referrals to a specialist, and an authorization is not in place, please send a secured message on our patient portal or contact our Business Office at the above phone number at least 5 working days prior to an appointment.

**APPOINTMENTS**

- Please arrive 20 minutes prior to scheduled appointment time. Be aware if you arrive late, you may be rescheduled.
- Cell phones — please turn off (or set to silent) while you are in the Clinic building.
- Bring blood pressure and/or blood sugar logs and medications or accurate medication list to all appointments.
- Although you may have someone accompany you for your appointment, we will only discuss matters for the scheduled patient.
- Please be aware that we may not be able to address all of your concerns at one visit—we may have to make a separate appointment to allow adequate time to each of your problems.

**CANCELLATION** If you are unable to keep your appointment please let us know as soon as you can. If possible, we would prefer 24 hours advance notice on cancellations to allow others the opportunity to be seen.

**CHANGES** ***(Address or Insurance Companies)*** Send changes on our patient portal or call the Business Office at 541-472-5580.

**HIPAA** According to HIPAA guidelines we are to discuss your medical issues only with you or people you have designated in writing. If you would like to designate someone other than yourself, please obtain form at the Information Desk.

**GRIEVANCES** may be reported to the Patient Services Department at 541-472-5515

If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our HIPAA Contact Person. You have the right to request a copy of your health information in electronic form if we store your health information electronically.

We may deny your request to inspect and/or copy records in certain limited circumstances. If you are denied copies of or access to health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

**Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to our HIPAA Contact Person.

We may deny your request for an amendment if your request is not **in writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy.
- Is accurate and complete.

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be 2 pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

To obtain this list, you must submit your request **in writing** to our HIPAA Contact Person. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

***We are required to agree to your request*** if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION to our HIPAA Contact Person.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION to HIPAA Contact Person. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

To obtain such a copy, contact our HIPAA Contact Person.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

## BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

## COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the HIPAA Contact Person, 495 SW Ramsey Ave, Grants Pass, OR 97527, Phone 541-476-6644. ***You will not be penalized for filing a complaint.***

Grants Pass Clinic, L.L.P.
495 SW Ramsey Ave. Grants Pass, OR 97527
541-476-6644 Fax 541-472-5673

# NOTICE OF PRIVACY PRACTICE

EFFECTIVE DATE 12/8//2020

*THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.*

## PLEASE REVIEW IT CAREFULLY

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR HIPAA CONTACT PERSON AT 541-476-6644 OR THE ADDRESS ABOVE.

## WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel.

## YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

**For Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. This information may be faxed between offices.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical

care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

**For Payment**. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will pay for the treatment.

Our billing system uses family accounts so you may receive one statement for all the family members on your account. Please let us know if you would like separate statements.

**MINORS: If you are a minor acting on your own behalf, you need to discuss payment arrangements with the credit office prior to being seen.**

**For Health Care Operations.** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

**Appointment Reminders.** We may contact you as a reminder that you have an appointment for treatment or medical care at the office. This may be done by telephone, text message, and/or by mail. We may leave a discreet voice message regarding your appointment.

**Mailings**. We may mail or email you certain items including but not limited to appointment reminders, test results, payment receipts, or notices about our practice.

**Treatment Alternatives.** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services.** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us **in writing** (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

**Sharing PHI via a Health Information Exchange.** We participate in Health Information Exchanges which allow your medical information to be shared electronically with other medical facilities and providers involved in your care. Sharing this information with other providers helps them make better decisions about your care. Participation in the exchange is voluntary and you have the right to opt out. If you choose to opt out, we will not share your information without your authorization. Opting out of the exchanges will not affect the treatment you receive at Grants Pass Clinic. The opt out form is available at our information desk.

## SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.

**Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

**Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

**Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. Another example would be informing a person who is here to provide transportation know where they might find you.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

## OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, **in writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially-protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to our HIPAA contact person in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

## WHAT YOU CAN EXPECT

A Patient-Centered Primary Care Home is a health clinic that is recognized for their commitment to patient-centered care. And just as it sounds, patient-centered care is all about you and your health!

Primary care homes are:

- **Accessible:** Care is available when you need it, including someone you can talk to after hours if you have health concerns
- **Accountable:** Your primary care home is responsible for providing the highest quality care to you and the community they serve
- **Comprehensive:** You get all the care, information and services you need to stay healthy
- **Continuous:** Your health care providers get to know you and work with you over time to reach your health goals
- **Coordinated:** Your health care providers help connect you with the care you need in a safe and timely way
- **Patient & Family Centered:** You and your family are the most important part of your health. Your care is delivered with respect for your cultural background, and in your preferred language

Oregon Health Authority

PATIENT CENTERED PRIMARY CARE HOME

The Patient-Centered Primary Care Home Program recognizes clinics as primary care homes and makes sure they meet the standards of care. The program is part of the Oregon Health Authority whose goal is to improve the health and care of all Oregonians.

www.PrimaryCareHome.oregon.gov

Type Clinic name

Type Clinic phone or delete text

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Type Clinic website or delete text

Type Clinic address or delete text

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OHA 9910 A REV. (7/12)

## WE ARE A RECOGNIZED

PATIENT CENTERED PRIMARY CARE HOME

We're committed to **better health** and **better care** for you and your family.

## As your primary care home, we will:

- Better coordinate your care to help get you the services you need, when you need them
- Listen to your concerns and answer your questions
- Offer after-hours help and alternatives to the emergency room
- Help you play an active role in your health

## Getting the best possible care

Your primary care home will make prevention and wellness a top priority. If you have a special health concern or condition, your health care team will help connect you with other health professionals to get you the care you need. For example, they can connect you with a nutritionist, behavioral health specialist, or a care manager — whatever your health needs call for. This is your health care team.

## Your health care team

Your health care team is led by your primary care provider, and everyone will work together to make sure they're on the same page when it comes to your health. This ensures you get the best possible care.

# YOUR NEXT APPOINTMENT

## Your health care team wants you to speak up!

- Bring a list of questions and tell your care team what health issues you want to focus on first — tell them what's important to you
- Use your own words to repeat back the things you've discussed. This way, you and your care team will know the information is clear
- Ask your care team how to reach them after hours
- Before you leave, be sure you know when your next appointment is and the things you can work on to improve your health