Pearl Health Center
centered on you.

Patient Information

Legal Name (First, MI, Last):_____ Date of Birth: _____ Sex M:____ F:____

Preferred Name (Nickname): _____ Gender you identify as: _____ Preferred pronoun: _____

Address: _____ City/State: _____Zip:_____

Phone: (home) _____ zΩ .Ω(work):_____

(cell):_____

Email (to enroll in Patient Ally):_____ SSN: _____

Pharmacy: _____ Phone: _____

Marital status:_____Occupation: _____Employer: _____

Employer Address:_____

Ethnicity: (Optional) ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

Race: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Preferred Language: _____ Would you like an interpreter present at your appointments: _____

How did you hear of us? Insurance Friend/Family Walking-by Internet Events Media Other: _____

I hereby authorize The Pearl Health Center Provider(s) and Medical Staff to communicate with me regarding my medical status and/or conditions via:

☐ Telephone: Phone Number_____

**Detailed Messages may be left by medical staff on the phone number listed above: Y _____ N _____

Emergency Contact

Contact Name: _____ Relationship:_____

Address: _____ Phone:_____

May we release medical information to this person? Yes _____ No _____

INSURANCE INFORMATION

Insurance Co: _____ Member ID#: _____

Group#_____ Telephone_____

Primary Insured Name: _____ Relationship to member: _____

Primary Insured Date of Birth: _____ Primary Insured Address: _____

Please check all of the services that you are interested in:

☐ Primary Care ☐ Mental Health ☐ Weight Loss ☐ Fine Lines/Wrinkles ☐ Spider veins ☐ Massage
☐ Chiropractic ☐ Acupuncture ☐ Naturopathic ☐ Travel Medicine ☐ Other:_____

LEGAL REQUIREMENT

☐ I authorize the Pearl Health Center to treat me. Services may include conventional, as well as complementary and alternative medicines, as indicated.

☐ I authorize all insurance payments to be made directly to the Pearl Health Center. I consent to the release of all information the insurance company may request for filing my claims.

☐ I have received and reviewed the handout called Privacy Practices Notice. I understand that I can ask for further information if needed.

Appointment Cancellation and Billing Policy

We realize that emergencies occur. However, in order to help us be available to patients who would like to be seen, we request that you notify us within a minimum of 24-hours if you need to cancel or reschedule an appointment. More than two last-minute cancellations or failure to show for an appointment may result in discharge from the practice.

☐ I have read the payment and collection policy on the back of this form and understand that I am ultimately responsible for any charges not covered by insurance.

Signature of Patient or Responsible Party_____ Date:_____

Pearl Health Center Payment and Collection Policy

The entire team at the Pearl Health Center is focused on making your healthcare experience as successful as possible. This includes helping you understand your bill. We hope the following will help clarify the most frequently asked questions.

Insurance Benefits

1. We are happy to bill your insurance plan for the care provided to you. We participate with most plans. As a courtesy, we typically call your insurance company to verify your benefits, deductible and copay amounts and we advise you do the same. Should your plan require a referral or authorization for a service, we will attempt to obtain it. ***However, the benefits of your insurance is between you and your insurance company.***

2. Laboratory specimens are sent to an outside lab for processing and you may receive an additional bill from the lab. Since all charges are your responsibility to pay, we urge you to contact your plan should you have questions about your benefits or the way your insurance company may process your claim.

Copays

Copays and/or deductibles are due at the time of service.

No insurance?

If you do not have insurance coverage, we offer a cash-pay discount for payment in full at the time of service. Cash prices are available upon request but they are not available for all services. Keep in mind that outside lab services will be at an additional cost.

Monthly Statements

Statements are sent monthly and we ask that you will pay any balance due within 30 days.

Unpaid accounts

Accounts over 90 days past due without a payment plan will be entered into a collection process which may affect your credit. If you have questions or concerns about your bill please call our business office at 503-525-0090, Option 3. Monthly payment arrangements to work within your budget are available. Past due accounts must be paid in full or payment arrangements made before further care is obtained at the clinic.

Please keep us informed of any changes in your insurance plan eligibility and update us if your address or telephone number changes.

Overpayments

Overpayments are identified periodically and refunds of amounts over $10 occur automatically. Refunds of overpayments less than $10 may be obtained by calling our business office.

Patient Signature: _____ Date: _____

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Health History

Please take the time to fill in this information.

Name: _____ Date: _____

Age: _____ Date of Birth: _____Occupation: _____

How long has it been since your last medical evaluation? _____

When was your last Dental Appointment?_____

Do you follow any special diet? If yes, please describe: _____

Tobacco? Yes ☐ No ☐ If yes, how many per day? _____ How many years have you used tobacco? _____

Alcohol? Yes ☐ No ☐ If yes, how many drinks per week? _____

Caffeinated drinks? Yes ☐ No ☐ How many per day? _____

Regular exercise? Yes ☐ No ☐ Please describe: _____

Please list any **allergies or sensitivities to medications**: Check here if none: ☐

Allergy:	**Type of Reaction:**
_____	_____
_____	_____
_____	_____
_____	_____

If you have personal reasons to not receive blood products, please check here: ☐

Current Medications (prescription & non-prescription, please include dose):

_____	_____
_____	_____
_____	_____

Herbs and Supplements:

_____	_____
_____	_____
_____	_____

Immunizations:	Date		Date
Tetanus booster (every 10 years):	_____	Pneumonia:	_____
Hepatitis A:	_____	Flu vaccine:	_____
Hepatitis B:	_____	Other: _____	_____
Pertussis booster:	_____	_____	_____

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Health History

Please take the time to fill in this information.

Personal Medical History: *please circle yes or no*

High blood pressure:	Y	N	Stroke:	Y	N
Gastrointestinal disorder:	Y	N	Seasonal allergies:	Y	N
Cholesterol problems:	Y	N	Serious infections:	Y	N
Acid reflux:	Y	N	Cancer:	Y	N
Heart disease:	Y	N	Chronic Pain:	Y	N
Hepatitis:	Y	N	Type: _____		
Thyroid disorder:	Y	N	Location of pain: _____		
Irritable bowel:	Y	N	Stomach Ulcer:	Y	N
Frequent bladder infections:	Y	N	Type: _____		
Kidney disease:	Y	N	Diabetes:	Y	N
Incontinence:	Y	N	Type: _____		
Anemia:	Y	N	Skin Condition:	Y	N
Respiratory problems:	Y	N	Type: _____		
Bleeding/clotting disorder:	Y	N			
Asthma:	Y	N			

Other illnesses: _____

Please list any surgeries: _____

Do you have a tendency for depression? Y N

If yes, what treatment has been helpful? _____

Family History:

	Relationship to you		Relationship to you
Diabetes	_____	Alcoholism	_____
Heart Disease	_____	Depression	_____
High Blood Pressure	_____	Bleeding Disorder	_____
High Cholesterol	_____	Strokes	_____
Prostate Cancer	_____	Arthritis	_____
Breast Cancer	_____	Thyroid Disease	_____
Other Cancers	_____	Osteoporosis	_____

Please specify any specific issues or problems you would like to address today:

_____

_____

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Health History

Please take the time to fill in this information.

933 NW 25th Ave
Portland, OR. 97210
PearlHealth.Center

Pearl Health Center
centered on you.

Phone: 503 · 525 · 0090
Fax: 971 · 244 · 0219

Physician and Patient/Family Bill of Rights and Responsibilities

The Pearl Health Center believes your health care is based on a partnership between the patient, providers and office staff. The partnership is designed to facilitate informed decision-making.

You have the Right to:

1. Expect privacy and respect while you receive your health care.
2. Always receive polite and respectful care.
3. Receive health care that is based on standards and guidelines.
4. Expect timely and reasonable answers to your questions.
5. Be seen within reasonable time.
6. Know who is in charge of approving and administering your procedures or treatment.
7. Know what services are available to help you.
8. Be given care that is sensitive to one's developmental needs.
9. Have access to your medical records based on state and federal laws.
10. Be told of medical choices for care or treatment.
11. Refuse treatment, except that written by law, and to be told of the effects of your choice.
12. Receive access to medical treatment no matter your race, sex, creed, sexual orientation, nationality, religion, disability or source of payment.
13. Practice your cultural values and spiritual beliefs as long as they do not interfere with the well-being of others or are within the limits of the law.
14. A copy of your bill and explanation of charges upon request.
15. Participate in decisions about your health care.

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You Are Responsible for:

1. Giving true and complete information about your present and past health, and family history.
2. Telling your provider of any change in your health.
3. Providing information to your provider about any care you received outside of our practice.
4. Letting us know of any concerns.
5. Telling your provider if you do not understand your plan of care and what is expected of you.
6. Keeping appointments when scheduled and notifying us in advance if you cannot.
7. Following the plan of care agreed upon by you and your provider.
8. Being responsible for your actions if you refuse treatment or do not follow the agreed upon plan of care between you and your provider.
9. Assuming financial responsibility for care received.
10. Being considerate of the rights of others and following office policies.
11. Respectful interactions with providers and staff involved in your child's care.

Copies of this notice may be obtained from the front desk.

Patient Name: _____

Patient Signature: _____

Date: _____

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Privacy Policy

This notice describes how medical information about you may be used, disclosed, and how you can obtain access to the information. **PLEASE REVIEW CAREFULLY.**

Our Responsibility

By law we are required to safeguard your PROTECTED HEALTH INFORMATION (PHI). Your PHI includes data about your past and present health conditions, the service provided to you, and the payment for said health care. This notice advises you of your rights and explains when, why, and how we can legally release your PHI to a third party outside of our practice. We take the responsibility seriously and promise to make every effort to execute them in an efficient manner.

WE MAY USE AND DISCLOSE YOUR HEALTH CARE INFORMATION IN THE FOLLOWING WAYS

- **Treatment:** We may disclose your PHI to practitioners, office staff or other personnel in the clinic. We may also disclose your health care information to other providers who are involved in taking care of you and your health.
- **Payment:** We may disclose your PHI to bill and collect payment for the treatment and services we provide
- **For Health Care Operations:** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to other doctors, nurse practitioners, nurses, medical assistants, technicians, and other office personnel for review and learning purposes. We may also combine the medical information we have with medical information from other offices and groups to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.
- **Disclosures to Business Associates:** In certain circumstances, we may need to share your medical information with a business associate (i.e., transcription company, accountant, or attorney) so it can perform a service on our behalf. We will have a written contract in place with the business associate requiring it to protect the privacy of your medical information.
- **Appointment Reminders**: We may contact you by phone or leave a message on your home phone, work phone, cell phone or email as a reminder that you/your child has an appointment scheduled for treatment or medical care at the office. Please notify us if you do not wish to be contacted for appointment reminders.
- **Treatment Alternatives/Health-Related Benefits and Services**: We may tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you. Please notify us if you do not wish to receive communications about treatment alternatives or health-related products or services.
- **SPECIAL SITUATIONS**: We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:
- **Oregon Immunization Alert Program**: We will report your child's immunizations to the Oregon State immunization registry. Only authorized users have access to a child's immunization history.
- **Family and Friends**; We may release medical information about you to a friend or family member who is involved in your medical care 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 give 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 child's personal health information to both parents. 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. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **Research and Organ/Tissue Donation:** 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. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **As Required By Law or To Avert a Serious Threat to Health or Safety:** We will disclose medical information about you when required to do so by federal, state or local law; when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person; or for public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Military and Veterans/Law Enforcement:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may release medical information if asked to do so by law

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enforcement officials 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.

- **Workers' Compensation/Health Oversight Activities**: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government 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 medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena.
- **Coroners, Medical Examiners and Funeral Directors:** We may release medical 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.
- **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. Unless otherwise requested, we will send a chart summary when an Authorization is received. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have a special written authorization that complies with the law governing HIV or substance abuse records

Your Rights Regarding Medical Information about you

- **Right to Amend:** If you feel that medical 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 for as long as the information is kept by or for this office. To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM to the Practice Manager. We may deny your request for an amendment if it 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: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the medical information kept by or for the office; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete.
- **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 this notice electronically, you are still entitled to a paper copy of this notice.
- **Review and Receive Copies:** You may review and/or receive copies of your PHI, such as medical records and billing data. Under certain circumstances, a summary, or explanation of your PHI may be more helpful than the actual copies. If you agree, we will provide your health care information in the form you request. We may charge for a fee for copies, summary, or explanation. In limited situations, we may deny some or all your request. If we do, we will provide our rational in writing and offer an appeal procedure.
- **Right to Request Restrictions**: You have the right to request a restriction or limitation of the medical information that we use or disclose about you for treatment, payment or health care operations. We are not required to agree to your request except under certain limited circumstances. If you do not want the Pearl Health Center to disclose your medical information for a specific visit to a health plan and you notify the Practice Manager. This request must be in writing. We will not ask you for the reason for your request. Your request must specify how or where you wish to be contacted
- **Request accounting of disclosures:** You have the right to ask for a list of our disclosures of your PHI
- **Receive confidential communication by alternative means or at a secondary location:** We will accommodate any reasonable request to use alternative means of communication or use a secondary address

If you have any questions about this notice or if you are concerned that your privacy has been violated, Please contact our Practice Manager at (503) 525-0090.

Patient Name: _____

Patient Signature: _____

Date: _____

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933 NW 25th Ave
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p. 503.525.0090
f. 971.244.0219
Pearlhealth.center

Authorization to Communicate PHI

Patient Name: _____
Date: _____
Provider: _____

I hereby authorize The Pearl Health Center Provider(s) and Medical Staff to communicate with the following individual(s) regarding my medical status and/or conditions:

_____	_____	_____
Name	Relationship	Phone Number

☐ I hereby revoke this authorization on _____

_____	_____	_____
Name	Relationship	Phone Number

☐ I hereby revoke this authorization on _____

_____	_____	_____
Name	Relationship	Phone Number

☐ I hereby revoke this authorization on _____

☐ I hereby revoke this authorization on _____

Patient Signature: _____ Date: _____

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Appointment & Attendance Policy

Primary Care

- Four (4) missed or late-canceled appointments (24 hours or less) within 12 months will move you to Walk-In Only status.
- Late Arrivals:
    - 5+ Minutes: Appointment may be shortened.
    - New Patients: Arriving with less than 10 minutes left in appointment: Appointment will be marked as a Failure to Arrive. You must reschedule or wait for a same-day opening if available.
    - Established Patients:Arriving with less than 5 minutes left in appointment: Appointment will be marked as a Failure to Arrive. You must reschedule or wait for a same-day opening if available.

Chiropractic & Acupuncture

- If you miss or cancel an appointment late (less than 24 hours ahead) two (2) times, you won't be able to book your appointments in advance anymore.
- Instead, you will have to use our Same-Day Access. This means we will put your name on a waiting list, and we will only call you if someone else cancels or if a spot opens up that day. You can also call the clinic to see if there are any open spots for that day.

Mental Health Therapy

- If you miss or cancel an appointment late (less than 24 hours ahead) three (3) times, you won't be able to book your appointments in advance anymore.
- Instead, you will have to use our Same-Day Access. This means we will put your name on a waiting list, and we will only call you if someone else cancels or if a spot opens up that day. You can also call the clinic to see if there are any open spots for that day.
- Discharge Policy: Continued attendance failures may lead to formal discharge to allow others to receive care. Referrals for a transfer of care will be provided if this occurs.

I have read and understand the policies above.

Patient Name (Print): _____

Signature of Patient or Guardian: _____ Date:_____