Valley Women's Health, PC
2700 SE Stratus Ave, Suite 301
McMinnville, OR 97128

Phone: (503)-474-1148
Fax: (503) 434-6148

John B. Neeld, MD
Brandi J. Spence, MD
Gregory Eppard, MD
Erica Koltenuk, CNM
Andrea Humphrey, CNM
Shannon Sluys, CNM

Patient Information

Name:_____ Birth Date _____Sex:_____ Marital Status:_____

Street Address:_____PO Box:_____

City:_____State:_____Zip:_____

Home Phone _____Cell Phone: _____ Work Phone:_____

SSN:_____Employer:_____Occupation:_____

Employer Address:_____

Email address_____

Primary Care Physician _____Referred By:_____

Spouse/Parent/Legal Guardian

Name: _____Relationship:_____Birth Date:_____

Street Address: _____PO Box_____

_____
City State Zip

Home Phone:_____Cell Phone:_____Work Phone:_____

SSN:_____Employer:_____Occupation:_____

Insurance

Primary Insurance:_____Subscriber/ID#:_____Group#_____

Subscriber Name:_____DOB:_____Relationship to Patient:_____

Employer:_____

Secondary Insurance_____ Subscriber/ID#:_____Group#_____

Subscriber Name:_____DOB:_____Relationship to Patient:_____

Employer:_____

Emergency Contact

Name:_____Relationship:_____Phone:_____

Authorization/ Assignment of Benefits

I herby authorize Valley Women's Health employees to release to my insurance company any information acquired in the course of my examination or treatment (if minor, parent or guardian must sign).

I hereby agree to full responsibility for all expenses incurred by me or on behalf of the above named patient and hereby assign to Valley Women's Health any and all insurance benefits due me to full extent of my financial obligation to the treating physician or provider.

I understand my insurance coverage is a relationship between myself and my insurance company. I agree to financial responsibility for payment for charges incurred. I understand that a rebilling fee complying with Oregon State Law will be applied to any overdue balance and in the event of non-payment; I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Signed: _____Date:_____

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Please complete the following form regarding release of medical information. It is our clinic policy to comply with state and federal laws keeping medical diagnosis and treatment information confidential unless otherwise authorized by the patient. Medical information will only be disclosed to those listed on this form.

Patient Name: _____Date of birth: _____

Do we have permission to:

Leave a message on your cell phone voicemail?

Yes_____ No_____

Leave a message on your home answering machine?

Yes_____ No_____

May we contact you at work?

Yes_____ No_____

May we discuss your medical condition and/or medical history with other members of your household?

Yes_____ No_____

If yes, whom:_____

Relationship: _____Phone number: _____

Is there any medical condition and/or medical history that we may NOT discuss with other members of your household?

Yes_____ No_____

If yes, whom and what: _____

_____ _____

Signature of Patient Date

Office Financial Policy

In our continued commitment to provide quality health care in a nurturing and supportive environment as well as staying committed to offering affordable services, below is an outline of our financial alternatives and expectations.

Patient Financial Responsibility: Payment in full is expected upon receipt of your statement.

Co-Payments: Co-Payments must be paid at the time of your appointment. If you are unable to pay at check-in you may be asked to reschedule.

Insurance Billing: As a courtesy we will bill your insurance company for all services, any amount the insurance requires the patient to pay will be billed to you upon receipt of the explanation of benefits (EOB) from the insurance company. This includes co-pays not known at the time of service, co-insurances and deductible.

Medicare Patients: I acknowledge that I am financially responsible for any non-covered services under Medicare guidelines, as well as my 20% co-pay and any amounts applied to my yearly Medicare deductible. I am aware I will be asked to sign an Advanced Beneficiary Notice (ABN) at the time of service.

Delinquent Accounts: All accounts are considered delinquent if they are more than 60 days old. Nonpayment will result in collection actions.

Uninsured Patients: We ask that all services be paid at the time the service is rendered. We offer a discount to our patients that are uninsured. Please keep in mind that the discount is only available when payment is made at the time of service. New OB patients will require a $1500.00 deposit at your first visit.

Payment Plans: We can extend payment plans in some cases, please discuss this with our business office prior to receiving treatment. There is a **minimum** of $50/month required on all payment plans.

We accept Cash, Checks, Visa, and MasterCard

I have read and understand the Office Financial Policy for Valley Women's Health. My signature below indicates I agree to all terms outlined above and acknowledge regardless of insurance, I am ultimately responsible for payment of my account.

_____ _____

Signature of Responsible Party Date

Valley Women's Health, PC

Medication History Notice:
Acknowledgement

Patient Name:_____

Date of Birth_____

I, _____, understand that my physician may need access to my medication history and may work in conjunction with my pharmacy and / or insurance carrier in order to provide accurate medical treatment

_____

Patient Signature Date

_____

Personal Representative Signature Date

Pharmacy of choice: _____

For Office Use Only:

- Patient refused to sign
- Patient unable to sign due to communication/language barrier
- Patient unable to sign due to emergency
- Other (please explain)

_____

_____

_____

Office Representative Signature Date

Valley Women's Health, PC

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Valley Women's Health, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Valley Women's Health, PC Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Valley Women's Health reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Valley Women's Health, privacy officer at 2700 SE Stratus Ave, Suite 301, McMinnville, OR 97128.

With my consent, Valley Women's Health, PC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Valley Women's Health may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Valley Women's Health may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Valley Women's Health restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Valley Women's Health use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice already made disclosures in reliance upon my prior consent. If I do not sign this consent Valley Women's Health may decline to provide treatment to me.

_____	_____	_____
Patient Printed Name	Patient Signature/ Legal Guardian	Date

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____ have *(circle one)* Received / Declined a copy of **Valley Women's Health, PC**'s Notice of Privacy Practices.

_____	_____	_____
Patient Signature / Legal Guardian Signature	Date of Birth	Date

Valley Women's Health

New Patient Intake Form

Patient Name:	Today's Date:
Nickname:	Date of Birth:
Primary Phone:	Ok to leave voicemail?
Primary Care Physician:	Referred by:
Marital Status or Partner?	Number of people in household:
Highest level of education:	Occupation:

Preferred Pharmacy

Allergies

List Allergies	Reactions

Medications

Please include hormones, vitamins, herbs, and nonprescription drugs

Drug Name	Dosage	Prescriber	Drug Name	Dosage	Prescriber

Immunizations or Tests

	Date		Date
Tetanus-Diphtheria		Hepatitis A or B Vaccine	
Influenza Vaccine (flu shot)		HPV Vaccine	
MMR (Measles-Mumps-Rubella)		Varicella Vaccine	
Tuberculosis (TB) Skin Test		Pneumococcal Vaccine	

Family History

	Age(s)	Living/Deceased?	If Deceased, cause?
Parents			
Siblings			
Children			

Family Illnesses

Illness	Yes	Which relative? Age of onset?	Illness	Yes	Which relative? Age of onset?
Diabetes			Tuberculosis		
Stroke			Birth Defects		
Heart Disease			Alcohol/Drug Use		
Clots in Lungs/Legs			Breast Cancer		
High Blood Pressure			Colon Cancer		
High Cholesterol			Ovarian Cancer		
Osteoporosis			Uterine Cancer		

Social History

In order for us to provide the most compassionate and sensitive care for our patients, we ask the following questions regarding social history. We strive to provide a safe environment for our patients to discuss any topics with their care providers. If we can improve this mission in any way, please let us know.

	Yes	No	Please Explain
Do you currently or have you ever smoked cigarettes? If so, when and for how long?			
Do you drink alcohol? If so, how many drinks per week?			
Do you currently or have you ever used recreational drugs? If so, when and which drugs?			
Do you regularly use your seat belt?			
Do you exercise? If so, how often and for how long?			
Do you regularly consume dairy products or take a calcium supplement?			

Patient Name: _____ DOB:_____

Social History (continued)

	Yes	No	Please Explain
Do you identify as a member of the LGBTQIA+ community (Lesbian, gay, bisexual, transgender, questioning, intersex, asexual)? Please share with us how you identify in terms of sexual and gender orientation, if you feel comfortable.			
Have you ever experienced unwanted or forced sexual contact? If so, when?			
Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone? If so, when?			
Have you ever felt threatened, controlled by, or afraid of a partner, family member, or caregiver? If so, when?			

Operations/ Hospitalizations

Reason	Date	Hospital	Reason	Date	Hospital

Gynecological History

Have you ever had sex?	Are you currently sexually active?
Age your periods began:	Current birth control:
Length of periods (in days):	Recent change in periods?
Age at menopause:	History of STDs/STIs?
Date of last mammogram:	History of pelvic pain?
Date of last Dexa scan:	Date of last colonoscopy:
Regular breast self examinations?	History of abnormal paps?
Date of last pap smear:	Last pap smear result:

Obstetric History

Number of Pregnancies:	Number of Abortions:	Number of Miscarriages:
Number of Premature Births:	Number of Live Births:	Number of Living Children:

Patient Name:_____ DOB:_____

Obstetric History: Delivery Information

	Birthday	Weight	Sex	Weeks PG	Delivery Type	Complication
1						
2						
3						
4						
5						

Personal Medical History

___ Anemia	___ Fatigue	___ Osteoporosis/ Osteopenia
___ Anxiety/ Depression	___ Gastrointestinal Problems	___ STDs/ STIs
___ Asthma	___ Urinary Tract Problems	___ Seasonal Allergies
___ Breast Problems	___ Head/ears/eyes/nose/throat	___ Thyroid Problems
___ Cancer	___ Hypertension	___ Blood Clots
___ Skin Problems	___ Headaches/ Migraines	___ Varicosities
___ Diabetes	___ Heart Disease	___ Contacts/ Glasses

Current or Past Healthcare Providers

Provider's Name	Current or Past?	Provider's Name	Current or Past?

Injuries/ Accidents/ Illnesses

Type	Date	Type	Date

Additional Information

Patient Name: _____ DOB: _____