IMPORTANT:

YOU NEED TO CALL YOUR INSURANCE COMPANY AND CHANGE YOUR PCP TO

CASEY LULAY, MSN, FNP-C or

JILL COHEN, DNP, FNP-C (depending on who your new PCP will be) BEFORE WE CAN GET YOU SCHEDULED. WE LOOK FORWARD TO PROVIDING YOUR HEALTHCARE NEEDS! THANKS!

SANTIAM
MOBILE MEDICINE

Santiam Mobile Medicine
1881 W Washington St.
Stayton, OR 97383
Phone: 503-507-5356
Fax: 866-225-2708
Email: Info@SantiamMobileMedicine.com
Office Hours: Monday-Friday 8:00AM-4:30PM & Monday-Thursday 7:00AM-8:00AM for telemedicine
After Hours phone: 503-507-5356

Welcome to Santiam Mobile Medicine
Your Patient Centered Primary Care Home (PCPCH)

Your Health Care Team: Your health care team consists of Casey Lulay, FNP-C. We coordinate care with WVP Clinical Support Providers which consists of: Licensed Clinical Social Worker, Registered Dietician, Behaviorists, and Clinical Pharmacists. We want to ensure you have the best possible care at Santiam Mobile Medicine.

Meet Your Provider(s):
Name: Casey Lulay, FNP-C
Specialty: Family Practice
Medical School: Gonzaga University
Board Certification: AANP
Philosophy: "I strive to make all the patients I come in contact with feel at ease. I ensure that they, and their family, are cared for with compassion, respect, kindness, and empathy. I also believe that prevention is key to effective healthcare."
Personal Interests: horses, boating, hunting, camping, spending time with family and friends
Name: Jill Cohen, DNP, FNP-C
Specialty: Family Practice
Medical School: University of Portland
Board Certification: AANP
Philosophy: She enjoys caring for people of all ages and is particularly interested in preventative care.
Personal Interests: pilates, traveling, watching softball and hockey, and spending time with her family and friends

Patient Portal:
Ask us how to connect with your provider using Patient Portal!

- Correspond with your provider online via our secure portal at https://19033.portal.athenahealth.com
- View, download or share your personal health record including data such as: medications and test results
- Get 24/7 access to important health and educational information
- Request prescription refills
- Get appointment reminders
- Maintain account data including user name, password and access privileges
- Payments on accounts through the Portal

Remember to visit our website for more valuable information about our practice: www.santiammobilemedicine.com

Urgent and Emergent Care:
All true emergencies should be transported via ambulance service (911) to the well-staffed nearest emergency room. We prefer that you contact us with your after-hours urgent problems rather than resorting to expensive and unnecessary Emergency Room visits.

Acute Care:
We will always attempt to schedule an appointment for the same day you call. If we cannot get you an appointment for that day, based on severity we will see you as soon as our schedule permits.

Referrals to Specialist:
Most insurance companies require the primary care provider to submit a referral notice for approval by the insurance company before a specialist visit occurs, or the charges for the visit may not be covered by your insurance company and these charges will be your responsibility. For some insurances this can take several days to process. If we have referred you to a specialist, and you have an insurance plan that requires provider office initiated notification and/or approval, then you must check with your insurance company to verify the specialist is covered by your policy. We will then take care of the rest. Retroactive or backdated referrals cannot be made. Please ask if you have any questions about this important process.

Prescriptions:
We write prescriptions for the number of intended refills after which we feel a follow up visit is necessary. Please call the office for an appointment when you fill your last refill. Refill requests sent through the pharmacy or patient portal will be filled within 48 hours. Prior Authorizations for controlled substances will not be obtained. We do NOT prescribe long-term opioid pain medications, we can refer you to a pain clinic to help manage your chronic pain.

Continuity of Care:
One of the most valuable things providers can offer their patients and their family is continuity of care. The provider's personal knowledge of the patient and his or her family is a valuable asset. As it grows, it adds immensely to the propriety and efficiency of the management of the patient's medical problems and preventative care.

Services:
Our office is your entry into the healthcare system. Most of your needs can be provided directly at the office. In addition to our services listed below, we also offer our Clinical Support Providers; Licensed Clinical Social Worker, Registered Dietician, Behaviorists, and Clinical Pharmacists. At the request of patient, family, or hospitalist, we would be happy to consult and advise the care team in our hospital patients, as well as coordinate your discharge, and request to see ALL hospitalized patients within 7 days of leaving the hospital. Please call our office as soon as you are admitted to the hospital.

Our Services Include:
- Preventative Well Female/Well Male Exams
- Well Child Checks and Sport Physicals
- Chronic Medical conditions
- Office and Minor Surgery: (ie skin biopsies, incision and drainage, joint injections)
- Mental Health

Patient Grievance Policy:
To provide patients and/or their families, other health care providers, or any other entity involved, an opportunity to express concerns regarding services rendered at Santiam Mobile Medicine. These concerns will then be reviewed, addressed and resolved. The aim is to increase patient satisfaction, improve quality of care, and better identify areas that need improvement with a timely response to complaints. You may inquire with any staff member regarding this process.

At Your First Appointment, Be Prepared To:
- Arrive 30 minutes early
- Bring <u>all</u> records from your previous Primary Care Provider including any mental health records if applicable
- Current Insurance Cards
- Personal Identification
- New Patient Intake form

All non-emergent medical triage calls will be returned by the end of the next business day.

After Hours:
There is always a provider available after hours. If you have a problem that arises after hours call our office at 503-507-5356. If Casey is not available, he has other providers take call for him.

Missed Appointments and Late Arrivals:
Please cancel appointments at least 24 hours in advance. Failure to cancel appointments causes unexpected gaps in scheduling resulting in long delays for other patients and late hours for the staff. Any patient who misses 3 appointments within a calendar year will be discharged from the practice.

We reserve the right to reschedule patients who arrive late for appointments.

Patient Registration Form

Santiam Mobile Medicine LLC
Address: 1881 W Washington St. Stayton, OR 97383
Phone: (503) 507-5356 ● Fax: (866) 225-2708

Casey Lulay, MSN, FNP-C

Jill Cohen, DNP, FNP-C

Patient Information

First Name	**M.I.**	**Last Name**	
Preferred Name	**Date of Birth**	**Legal Sex**	

Race: (check one)	**Ethnicity: (check one)**	**Sexual Orientation: (check one)**
☐ Decline to Answer	☐ Decline to Answer	☐ Choose Not to Disclose
☐ Asian ☐ American Indian/Alaska Native	☐ Not Hispanic/Latino ☐ Cuban	☐ Straight or heterosexual
☐ White ☐ Native Hawaiian/Pac. Islander	☐ Dominican ☐ Hispanic or Latino/Spanish	☐ Lesbian, gay or homosexual
☐ Black/African American	☐ Latin American/Latin, Latino ☐ Mexican	☐ Bisexual
☐ Other	☐ Central American ☐ Puerto Rican	☐ Something else please describe
	☐ South American ☐ Spaniard	☐ Don't know

Gender Identity: (check one)	**Assigned Sex at Birth: (check one)**	
☐ Choose not to disclose	☐ Choose not to disclose	
☐ Identifies as Male ☐ Identifies as Female	☐ Male	
☐ Transgender Male/Female-to-Male (FTM)	☐ Female	
☐ Transgender Female/Male-to-Female (MTF)	☐ Unknown	
☐ Gender non-conforming		
☐ Additional gender category/other, please specify		

Marital Status	**Primary Language**
Mailing Address	

City	**State**	**Zip**

Home Phone	**Work Phone**	**Cell Phone**	**Preferred Phone: (check one)** ☐ Home ☐Work ☐Cell

Fax Number (if applicable)	**Email Address**
Preferred Method of Communication □Mail □Phone □Portal	**Patient Notes**

☐ *Check here if same as above*	**Guarantor Information:** (Person who is financially responsible)				
First Name / **M.I.**	**Last Name**	**Sex**	**Date of Birth**	**SSN (optional)**	
Mailing Address	**City**	**State**	**Zip**	**Marital Status**	
Home Phone	**Work Phone**	**Cell Phone**	**Preferred Phone: (check one)** ☐ Home ☐Work ☐Cell		
Relationship to Patient	**Email Address**				

Emergency Contact Information:		
First Name	**Last Name**	**Relationship to Patient**
Contact Number	**Alternate Contact Number**	

Next of Kin Contact Information:		
First Name	**Last Name**	**Relationship to Patient**
Contact Number	**Alternate Contact Number**	

Employment		
Employer Name	**Employer Phone**	**Usual Occupation**

Guardian		
First Name	**Last Name**	**Relationship to Patient**
Contact Number	**Alternate Contact Number**	

Preferred Pharmacy/Lab/Imaging Information:	
Pharmacy: **Lab:** **Imaging:**	**General Location (city and/or street name)**

Patient Name:_____

Date of Birth:_____

Please complete the information below or supply us with a copy of your insurance card(s), both front & back:

☐ *Check here if you do not have insurance* **Primary Insurance Information:**		
Name of Insurance Company	**ID/Policy Number**	**Group Number**
Address of Insurance Company	**Do you have a co-pay**? ☐ No ☐ Yes - amount_____	**Phone Number**
Policy Holder/Guarantor (person carrying insurance)	**Policy Holder's Date of Birth & SSN**	**Relationship to Patient**
Secondary Insurance Information: (if applicable)		
Name of Insurance Company	**ID/Policy Number**	**Group Number**
Address of Insurance Company	**Do you have a co-pay?** ☐ No ☐ Yes - amount_____	**Phone Number**
Policy Holder/Guarantor(person carrying insurance)	**Policy Holder's Date of Birth & SSN**	**Relationship to Patient**

Please complete the information below if you are seeing us due to an automobile accident:

Automobile Insurance Information: (if applicable)		
Name of Insurance Company	**Claim Number**	
Claims Address for Insurance Company		**Date of Accident**

Patient Name:_____

Date of Birth:_____

Personal Health History

(Please fill out your Health History information as accurately as possible. This information is a confidential record)

Have you ever had the following? Check all that apply

ADD/ADHD	☐	Blood Disorder	☐	Epilepsy	☐	Hepatitis	☐	Migraines	☐
AIDS	☐	Blood Transfusion	☐	Gastric Ulcer	☐	Hiatal Hernia	☐	Mononucleosis	☐
Alcoholism	☐	Cancer (what kind)	☐	Genital Herpes	☐	Inguinal Hernia	☐	Mumps	☐
Anemia	☐	_____		Genital Warts	☐	HIV	☐	Osteoarthritis	☐
Anorexia	☐	Chickenpox	☐	GERD	☐	High Cholesterol	☐	Osteoporosis	☐
Anxiety	☐	Chlamydia	☐	Glaucoma	☐	High Blood Pressure	☐	Pneumonia	☐
Irregular Heart Beat	☐	COPD	☐	Goiter	☐	Erectile Dysfunction	☐	Rheumatic Fever	☐
Arthritis	☐	Depression	☐	Gonorrhea	☐	Irritable Bowel	☐	Scarlet Fever	☐
Asthma	☐	Diabetes Type 1	☐	Gout	☐	Kidney Disease	☐	Stroke	☐
Back Pain	☐	Diabetes Type 2	☐	Hearing Loss	☐	Kidney Infection	☐	Thyroid Disease	☐
Bipolar Disorder	☐	Drug Addiction	☐	Heart Attack	☐	Kidney Stone	☐	Tuberculosis	☐
Bladder Infections	☐	Eczema	☐	Heart Disease	☐	Liver Disease	☐	Whooping Cough	☐
Legally Blind	☐	Emphysema	☐	Hemorrhoids	☐	Measles	☐	Other	☐

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all medications and supplements you take regularly (if necessary, attach additional sheet of paper)

Medication	Dose	Frequency (how often)	Prescribing Provider (or state if over the counter)

Please list all medication allergies and the reaction you have. ☐ **No Known Drug Allergies**

Allergic To:	Reaction	Allergic To:	Reaction

Patient Name:_____

Date of Birth:_____

Social History: **(**circle your answer)

Do you smoke? **Never Former Quit**-when?_____ **Yes**-how much/how often/#pack years_____

Do you use smokeless tobacco? **Never Former Quit**-when?_____ **Yes**-how much/how often?_____

Do you vape or use e-cigarettes? **Never Former Quit**-when?_____ **Yes**-how much/how often?_____

Do you drink alcohol? **Never Former Quit**-when?_____ **Yes**-how much/how often?_____

Do you use illicit drugs? **Never Former Quit**-when?_____ **Yes**-how much/how often_____

Do you use caffeine? **No Yes**-what kind and how often?_____

How much exercise do you get? **None Occasional Moderate Heavy**

Do you have a living will, Advanced Directive or POLST? **Yes No** (if yes please provide us a copy for your records)

Are you Adopted? **Yes No** Transportation difficulty? **Yes No** Seen a dentist in the past year? **Yes No**

Any trouble paying for basic things like food or housing? **Yes No**

Family Health History:

Has any blood relative had any of the following? Be as specific as possible: for example "maternal grandmother"

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Alcohol Abuse			Epilepsy		
Allergies			Glaucoma		
Anemia			Heart Disease		
Asthma			High Cholesterol		
Blood Disorder			High Blood Pressure		
Cancer – what kind			Kidney Disease		
Depression			Stroke		
Diabetes Type I			Thyroid Disease		
Diabetes Type II			Tuberculosis		

Women Only:

Menstrual Cycle	**Birth Control Method** (circle all that apply)	**Pregnancies**
Age your period began: _____	Virgin Abstinence None	Have you ever been pregnant? **No Yes**
Menopause: **No** **Yes**, since age _____	Natural Family Planning Withdrawal	How many children have you had? _____
How many days do your periods last? _____	Condoms Foam/Gel Diaphragm	Are they all living? **No Yes**
Length of entire cycle: _____	IUD Pill Patch Nuvaring	Have you had a miscarriage? **No Yes**
Menstrual Flow: **Light Medium Heavy**	Depo Vasectomy Tubal	If yes, how many? _____
Do you spot between periods? **No Yes**	Hysterectomy Essure Implanon	Have you had an abortion? **No Yes**
Date your last period started: _____ Date of last mammogram: _____		If yes, how many? _____

Date of last colonoscopy: _____

If you are in need of an appointment right away, what do you need to be seen for?

_____

How did you hear about us?

☐ Social Media ☐ Referred by a patient (patient's name)_____

☐ Web Search ☐ Other (please specify)_____

CONSENT AND CONDITIONS OF TREATMENT/FINANCIAL POLICY

Patient Name: _____ ("Patient") **Birth Date**: _____/_____/_____

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment of the Patient by ***Santiam Mobile Medicine LLC*** which will be known as "PRACTICE."

("PRACTICE") and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. If PRACTICE personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of Patient for any bloodborne disease for the protection of PRACTICE personnel.

CONDITIONS FOR TREATMENT AT PRACTICE. In consideration for the care and treatment that Patient will receive or has received at PRACTICE, I agree to the following:

Payment. I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and PRACTICE. I agree to make such payments according to PRACTICE's regular terms of payment. Where appropriate, I agree to submit and cooperate with PRACTICE in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to PRACTICE's policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.

Assignment and Authorization. I hereby assign and authorize direct payment to PRACTICE of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Practice or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Practice's right to use or disclose protected health information as otherwise allowed by applicable law or Practice's Notice of Privacy Practices.

Billing Practices. I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. PRACTICE may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that PRACTICE will require payment of all accounts at the time the services are rendered unless PRACTICE has expressly agreed to contrary arrangements. Where insurance is available, PRACTICE will bill and allow a reasonable time for the

insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at PRACTICE.

PERSONS FOR WHOM PRACTICE IS NOT LIABLE. I understand that PRACTICE is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by PRACTICE may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that PRACTICE is not liable for the acts or omissions of nonemployees or PRACTICE employees acting outside the course and scope of their duties.

INJURY CAUSED BY THIRD PARTY. I understand that if my condition was caused by the wrongful act or omission of another person I will let the PRACTICE know.

NOTICE OF PRIVACY PRACTICES. I have received a copy or been offered a copy of PRACTICE's Notice of Privacy Practices on this or a prior occasion.

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing our patients with affordable health care. Please read the following statement below carefully, so you understand our patient financial policy.

All co-payments, deductibles, and account balances may be required, before services are rendered, at each office visit. We may also request that you pay a deposit against your deductible. This arrangement is part of your contract with your insurance company and failure on our part in collecting co-payments/coinsurance and deductibles from our patients can be considered fraud per the Anti-Kick Back Law. Please help us in upholding the law by paying your co-payments/coinsurance and deductibles at each visit.

Non-Covered Services:

Please be aware that some, and perhaps all, of the services that your provider considers important, may be non-covered or considered reasonable and necessary by Medicare or other insurances. We may ask you to sign a financial responsibility waiver prior to receiving these services and request that you pay for the service prior to the service being rendered. Please be advised that non-covered services are the patient's financial responsibility, which may include screening questionnaires.

Proof of Valid Insurance and Claim Submission:

All patients must complete our patient registration form before seeing the healthcare provider. We must obtain a copy of your current and valid insurance card. If you fail to provide us, in a timely manner, with the correct insurance information you will be responsible for the balance of your insurance claim(s). If we have submitted your claim(s) to the insurance company you provided, with no error on our part, and we receive no response from

your insurance company after 45 days, the balance(s) will be automatically billed to you. Your insurance benefits are a contract between you and your insurance company and we are not a party to that contract. If you have questions related to why your insurance processed a certain way, you will need to contact your insurance company.

Insurance Pre-Certification/Authorization:
The clinic will make every effort to pre-certify and/or obtain written referral for all services and procedures that are required, provided the clinic is supplied with the necessary and correct information. In addition, the clinic will make every effort to certify ongoing authorization and referrals as needed. It is however, the responsibility of the patient to verify that all authorization and referrals are on file and have been approved by your insurance company.

Out of Network Insurance:
If the clinic is not an in-network provider with your insurance company, you may still have out of network benefits that would allow you to be seen. In the event that your insurance carrier pays you directly for services performed, you're required to turn over the check to our office within 7 days of receipt.

Non-Payment:
We are here to assist you with any billing related questions or to set up payment arrangements to satisfy your account balance within 6 months. However, if payment or a monthly payment arrangement has not been arranged with our billing department within 30 days after the patient balance is accrued, your account may be subject to a $30 late fee. We may find it necessary to refer your account balances to a collection agency for management and reserve the right to bill you for any attorney fees that may accrue due to non-payment. If you have a history of non-payment we may choose to discharge you and your immediate family members care from our facilities. We will send you a letter in the mail explaining to you that you have 30 days to find alternative medical care. During that 30 days, our provider will only be able to treat you on an emergency basis. Therefore, it is very important that you reach out to us, if you are struggling to pay your balance.

Non-Sufficient Funds (NSF):
Checks returned for Non-Sufficient Funds are subject to a reprocessing fee of $30.00. All balances that appeared to have been paid, will be returned to patient balance.

Missed Appointments: Our policy is to charge $25.00 for missed appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

To set up a payment arrangement or discuss financial hardship matters, please let us know.

For your convenience, we accept payment in the form of cash, check, money order, Visa, MasterCard, American Express, and Discover.

As patient, or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office as stated above. I also agree to pay service fees for overdue balances and missed appointments.

_____ _____

(Print Name) **(Date)**

_____ **(Signature)**

_____

Relationship to Patient/Authority

Authorization to Use/Disclose Protected Health Information

I authorize:

_____

(Name of individual/clinic who is disclosing health information such as previous PCP or specialists) **FILL OUT SEPARATE ONES FOR EACH PLACE**

To use and disclose health information described below regarding:
Name of Patient: _____ Date of Birth: _____

Name of where information should be sent:
Santiam Mobile Medicine – 1881 W Washington St. Stayton, OR 97383
●Phone:(503) 507-5356 ● Fax:(866) 225-2708

Type of information to be disclosed: ____ Office Visit Notes for last 2 years ____ Lab and test results for last 2 years ____ Current Medication List ____ Other – Please describe_____

For the purpose of: ____ Patient Care ____ Other - please describe_____

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 applicable space next to the type of information:

____ Alcohol/Chemical Dependency Diagnosis, Treatment, or Referral Information ____ Genetic Testing Information
____ HIV/AIDS Information ____ Mental Health 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 or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require 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. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

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 applicable above practice, and state you are revoking this authorization.

Unless revoked, this authorization expires: _____ or 12 months from the date of this authorization. (Insert applicable date or event)

I have read this authorization and I understand it.
Signature of patient or legal representative: _____

Relationship to patient: _____Date: _____

Authorization to Use/Disclose Protected Health Information

I authorize:

_____

(Name of individual/clinic who is disclosing health information such as previous PCP or specialists) **FILL OUT SEPARATE ONES FOR EACH PLACE**

To use and disclose health information described below regarding:
Name of Patient: _____ Date of Birth: _____

Name of where information should be sent:
Santiam Mobile Medicine - 1881 W Washington St. Stayton, OR 97383
●Phone:(503) 507-5356 ● Fax:(866) 225-2708

Type of information to be disclosed: ____ Office Visit Notes for last 2 years ____ Lab and test results for last 2 years ____ Current Medication List ____ Other – Please describe_____

For the purpose of: ____ Patient Care ____ Other - please describe_____

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 applicable space next to the type of information:

____ Alcohol/Chemical Dependency Diagnosis, Treatment, or Referral Information ____ Genetic Testing Information
____ HIV/AIDS Information ____ Mental Health 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 or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information and specifically require 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. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

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 applicable above practice, and state you are revoking this authorization.

Unless revoked, this authorization expires: _____ or 12 months from the date of this authorization. (Insert applicable date or event)

I have read this authorization and I understand it.
Signature of patient or legal representative: _____

Relationship to patient: _____Date: _____

Santiam Mobile Medicine: 1881 W Washington St. Stayton, OR 97383 ● Phone:(503) 507-5356 ● Fax:(866) 225-2708

Authorization to Share Medical Information

Patient Printed Name: _____

Patient Date of Birth: _____

Patient/Legal Guardian/Parent **Signature (sign here)**_____

We need your permission, by law, to be able to verbally communicate with your spouse, family, caregivers, parents (if you are over 18). We may need to verbally communicate with these people when discussing your appointments, financial or account information, discussing treatments performed or needed. Certain information that will ***not*** be shared without prior written consent includes genetic testing, mental health, drug and alcohol information, HIV/AIDS.

Please indicate below the names of whom we can verbally communicate with regarding your appointments, financial or account information, your treatment performed or needed:

1. My spouse _____
2. My family _____
3. Caregivers _____
4. My Parents _____
5. Other _____
6. Initial here if you do **not** wish to allow your information to be shared with anyone including your spouse, family or anyone else: _____

If you authorize us to leave a detailed message regarding your healthcare/medical information please let us know what **phone number** _____

Patient Name:_____

Date of Birth:_____

Santiam Mobile Medicine
Telemedicine/Telehealth/Secure Online Video Appointment Consent Form

Consent for Treatment: I consent to telehealth/telemedicine care performed by my physician and all other associated health care providers at Santiam Mobile Medicine. This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the Providers' professional judgment. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I also understand that I have the option to refuse the delivery of health care services by telehealth/telemedicine at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. If I am pregnant, this consent also applies to my fetus.

Consent for Telehealth/Telemedicine Services: Telehealth/Telemedicine involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

• I will be informed of any other people who are present at either end of the telehealth/telemedicine encounter and have the right to exclude anyone from either location.

• All confidentiality protections required by law or regulation will apply to my care.

• I have the right to refuse or stop participation in telehealth/telemedicine services at any time and request alternative services such as an in-person appointment. However, I understand that the equivalent in-person services might not be available at the same location as the teleheath/telemedicine services.

• If I do not want to receive health care services by telehealth/telemedicine, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled.

• If an emergency occurs during a telehealth/telemedicine encounter, 911 will be called and your Provider will stay on the video until help arrives.

Records and Release of Information: Transmitted Data may become part of my medical record. Data will not be transmitted to people outside of my health care team except as described below, and/or if I provide additional consent.

• I will have access to all of the information in my medical record resulting from the telehealth/telemedicine services that I would have for a similar in-person visit, as provided by federal and state law.

• The Provider may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.

• All releases of information are subject to the same laws and regulations as in-person care.

Payment Agreement/ Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance or their third party payors—except as prohibited by any state or federal law, or any agreement between my insurance company and the Providers of Santiam Mobile Medicine. I authorize the Providers and Santiam Mobile Medicine to file claims for payment of any portion of the patient's bills and assign all rights and benefits payable for healthcare services to the provider or organization providing the services. I agree, subject to state and federal

Patient Name:_____

Date of Birth:_____

law to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event the Providers or Santiam Mobile Medicine have to take actions to collect the same because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth/telemedicine services are covered under my insurance plan.

I understand that I may be billed and agree to pay all bills submitted by the Providers, Santiam Mobile Medicine, and/or other providers involved with the provision of telehealth/telemedicine services. Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, Santiam Mobile Medicine, and/or other providers involved with the provision of telehealth/telemedicine services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts that I may owe, the Providers, Santiam Mobile Medicine, and/or other providers involved with the provision of telehealth/telemedicine services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services.

By signing this document, you agree to the above consent for treatment and services through Telehealth/Telemedicine.

_____ _____

(Print Name) **(Date)**

_____ **(Signature)**

_____

Relationship to Patient/Authority