AUTHORIZATION TO DISCUSS HEALTH INFORMATION

I,_____,_____, authorize medical providers and personnel
(Name of Patient) (Date of Birth)

of Broadway Medical Clinic to discuss my protected health information (PHI) with the following persons:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

The purpose of this Authorization to Discuss Health Information form is to provide our patients an opportunity to permit the verbal release of their PHI.

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.

_____ HIV/AIDS information
_____ Drug/alcohol diagnosis, treatment, or referral information
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Genetic testing 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.

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 are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

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 the Release of Information Coordinator at Broadway Medical Clinic and state that you are revoking the authorization.

I have read this Authorization and I understand it. Unless revoked, this authorization expires 730 days (2 years) from date signed.

Please sign and date

_____ Date:_____
Signature of Patient/Personal Representative

PRINT Name of Patient/Personal Representative _____

Description of Representative's Authority: _____

Broadway
MEDICAL CLINIC

MRN _____

Date _____

Patient Name _____ Date of Birth _____

Dear new patient,

NEWBORNS

Most health plans require a newborn to be enrolled within 30 days from birth in order for medical providers to be paid for services provided. If you have not already done so, please contact your health plan or employer to add your newborn to your plan. Once the child has been enrolled please contact our office to provide us with the new insurance information. **If the child is *not enrolled within the required time limit* set by your insurance company, you will be responsible for payment in full for all charges.**

NEW PATIENTS

We request that patients have insurance at time of their visit. If no insurance is provided at the time of service/time appointment was made, **we will require a $90 deposit** at the time of check in. It is your responsibility to check with your insurance to make sure we are contracted and in network. If we are not, and they are not enrolled in an accepted insurance, **you will be responsible for payment in full for all charges.**

Please provide the following:

Name of insurance company: _____ Insurance phone number: _____

Policy/Member ID number: _____ Group number: _____

Claims address: _____

Is this insurance through (circle one): Employer Private Medicare OHP–Must be Healthshare Care Oregon

Please initial which pertains to you: _____I do not have other insurance _____I have a secondary insurance
(If you have secondary insurance, please add it below)

Name of insurance company: _____ Insurance phone number: _____

Policy/Member ID number: _____ Group number: _____

Claims address: _____

Is this insurance through (circle one): Employer Private Medicare OHP–Must be Healthshare Care Oregon

Patient/Guardian/Parent signature _____

Please print the signed name _____

4212 NE Broadway
Portland, Oregon 97213
(503) 249-8787 telephone
(503) 284-5168 fax

broadwaymedicalclinic.com

Broadway
MEDICAL CLINIC

PATIENT RESPONSIBILITY WAIVER

I _____ (Patient's Name) **OR**

Parent/Guardian Name: _____
(If patient is a minor)
Account # _____ Chart # _____, understand that:

☐ My insurance company **requires a referral** from my Primary Care Provider. I also understand that _____(specialist) has not received authorization for a referral from my Primary Care Provider.

☐ I do not have **a current copy of my insurance card** to provide to my physician. Please bill the insurance on file. I accept responsibility for any unpaid charges.

☐ **I do not have my copay** –I understand there is a $35.00 charge in addition to the copay amount

☐ I have been advised that my health insurance plan is **not –contracted**, or **out of network** for Broadway. I am choosing to be seen today at Broadway and accept responsibility for charges incurred today.

☐ I was involved in an accident involving a Motor vehicle. **I do not have car insurance**

☐ I understand that I am requesting services that **may not be approved or covered** for payment by my insurance company.

I therefore understand that I will be financially responsible for any and all charges incurred (including lab and x-ray) at the time of this visit.

Date of service_____

_____ _____
Patient Signature (Responsible Party) Date

_____ _____
Employee Witness Date

First in Primary Care Broadway MEDICAL CLINIC

FINANCIAL POLICY SUMMARY

Patient and/or Guarantor assume responsibility for all charges resulting from treatment provided by Broadway Medical Clinic, L.L.P. We bill most insurance carriers in expectation of prompt payment. Responsibility for unpaid balances is that of the Patient and/or Guarantor. Payment for service is due within 15 days of receipt of statement, unless financial arrangements are made in advance.

It is the responsibility of the Patient and/or Guarantor to understand the terms, deductibles, and conditions of their insurance plan*. Insurance providers do not always cover preventive or well care visits. Contact your carrier's Member Services Department for clarification. When insurance information is unavailable or valid insurance information is not provided prior to or at time of service, the Patient and/or Guarantor will be held responsible for charges incurred. A deposit will be collected at time of service of $100.00. The clinic has a self-pay fee schedule. No discounts are provided on laboratory, imaging or medication services.*

- **Divorced Parents –** Both parents are held **equally financially responsible** for services provided to minor child.

- **Uninsured Patients** – Patient and/or Guarantor, who do not have verifiable insurance at time of service, are required to pay a minimum of 100.00 deposit at every visit towards estimated charges related to their appointment.
- **Appointment Requirements** – In compliance with Federal Fraud and Abuse guidelines, we ask that Patient and/or Guarantor present at each visit*; Photo ID, the Patient's current insurance identification card(s),* and be prepared to pay all applicable co-pays. We also ask to be advised of any change in insurance coverage and communicate change in name, address, telephone numbers, and employer. The clinic is not responsible for claims billed outside the insurance guidelines if correct insurance information is not provided at time of service.

- **Co-payment** – Co-payments are due at the time of each visit. **Failure to pay a co-payment at the time of appointment will result in a $35.00 billing fee, in addition to the copay amount.** Your insurance company may apply an additional copayment at time of claim processing for such services as imaging, laboratory or procedures based on your plan design.

- **Health Insurance** – Broadway Medical Clinic, L.L.P. will bill most employer sponsored insurance carriers as a courtesy to our patients. Secondary insurance will be billed as a courtesy when information is presented at time of service. Newborns must be added to insurance within 30 days of birth. Please present picture ID and your insurance card at each visit.

- **Medicaid/Oregon Health Plan or other State subsidized plans** – Enrollees are required to bring their current Medicaid eligibility card Please be prepared to pay any applicable copayment at time of service.

- **Non-Covered Services by your health care plan-** Some services, including but not limited to immunizations, lab work, medical supplies Physicals, or preventative visits, may not be covered by your health plan. You may be asked to sign **a "notice of non-coverage"** to receive the services.

- **Motor Vehicle Accident** – Patient and/or Guarantor are required to inform Broadway Medical Clinic, L.L.P. at time of scheduling if services are related to a Motor Vehicle Accident. All charges related to a Motor Vehicle Accident (MVA) **are the responsibility of the patient**. However, we will bill the patient's automobile carrier as a courtesy but we do not hold for 3rd party liability.

- **Workers' Compensation Claims** – Patient and/or Guarantor are required to inform Broadway Medical Clinic, L.L.P. prior to each visit when medical services are related to a Workers' Compensation claim and to file an accident report with their employer and present proof of claim for medical services. An 827 is to be completed at the 1st point of care following the injury. **Should the claim be denied, Patient and/or Guarantor are responsible for the appeal process.**

- **Missed Appointment Fee**: A fee of $100.00 may be charged for missed preventive, dermatology and behavioral health appointments; all other appointments will be assessed $75.00 first missed appointment increasing to $100.00 for subsequent no show or not cancelled with 1 business notice.
- **Rebilling Fees**: Unpaid balances exceeding 8 weeks will be subject to a $5.00 per month rebilling fee.
- **Returned Check Fee / Declined Credit Cards**: A $35 fee will be charged if your check is returned from your bank unpaid or if your credit card is denied.

Signature: _____ **Date**: _____

You may contact our Financial Counseling Dept. at (503) 331-7665. updated 08/17/2021

MRN _____

BROADWAY MEDICAL CLINIC
PEDIATRIC PATIENT INTAKE FORM
(Please print clearly)

Child's full legal name _____

Name or nickname child likes to be called _____

Date of birth _____ Birth sex **(check one)** F M Identified gender _____

Which pediatrician are you establishing care with? _____

Would you like to identify your child's race/ ethnicity for our data collection? **(check one)** Yes No

(If yes, check all that apply) Asian Black/African American Caucasian Hispanic/Latino Native American Other

How did you hear about BMC (if referred by a patient/parent, please give name) (**check one)** Radio Ad TV Person Other

Referred by (if applicable): _____

PARENT INFORMATION	**PARENT 1**	**PARENT 2**
Full Legal Name		
Date of Birth		
Address		
City/State		
Zip Code		
Home Phone		
Mobile Phone		
Employer Name/ Occupation		
Employer Phone		
Email address **(please write legibly)**		

Parent's Marital Status **(check one)** Married Separated Divorced Unmarried Widowed

Primary address of the child **(check all that apply)** Parent 1 Parent 2

Parent with medical decision making rights for child **(check all that apply)** Parent 1 Parent 2

Other Primary Caregiver or Guardian (and role) _____

***Please provide copies of court orders related to primary residence, custody, decision making authority ***

We must have a signed consent on file for any other person than biological parents bringing child to appointments

EMERGENCY CONTACT - RELATIVE TO PARENTS (please list two)	
Name	
Relationship to patient	
Home phone	
Cell phone	
Name	
Relationship to patient	
Home phone	
Cell phone	

PLEASE COMPLETE BOTH SIDES OF INTAKE FORM

SOCIAL HISTORY
Names and ages of siblings (year of birth)
Who lives in the family home?
Does your child attend daycare? **(check all that apply)** Yes No nanny full time part time
Smokers around child (Include outside smokers)? Yes No father mother brother sister GF GM friend daycare
Pets in home? Yes No dog(s) cat(s) fish birds gerbils hamster other:
Guns in Home? Yes No Guns are kept **(check all that apply)** Unloaded Locked Ammunition Stored Separately
Within the last 12 months we worried whether or not our food would run out before we had money to buy more **(check one)** Yes No Within the past 12 months the food we bought did not last and we didn't have money to buy more **(check one)** Yes No

PRENATAL AND BIRTH HISTORY (if known)	
Any illnesses or complications during pregnancy? Y N	Any complications at time of delivery or after birth? Yes No Hospital (name, town/state):
Any smoking, alcohol or recreational drug use during pregnancy? Yes No	
Mother's OB doctor and clinic:	Birth weight:
	Were you seen in hospital by our BMC doctors? Yes No

PAST MEDICAL HISTORY	
Child's Previous Doctor (name, town/state): Have you requested records be sent to BMC? Yes No	Are immunizations up to date? Yes No Unknown Have you given us a copy of immunization report? Yes No
Hospitalizations/Surgeries **(check one)** Yes No **(list below if "yes")**	Food Allergy **(check one)** Yes No **(list below if "yes")**
1.)	1.)
2.)	2.)
Prior Problems **(check one)** Yes No **(list below if "yes")**	Medication Allergy **(check one)** Yes No **(list below if "yes")**
1.)	1.)
2.)	2.)

FAMILY HISTORY	
Does any member of the **CHILD'S IMMEDIATE** family have any of the following conditions? If so, please check and tell us who: **PGF = dad's father, PGM = dad's mother, MGF = mom's father, MGM = mom's mother, Uncle = child's uncle,** **Aunt = child's aunt, S = child's sister, B = child's brother, Mom = Mother, Dad = Father**	
Anesthesia Reactions	Heart Attack
Bleeding Disorders (hemophilia, VonWill)	High Blood Pressure
ADD/ADHD	High Cholesterol
Allergies	Kidney Stones
Anxiety	Osteoporosis ("bone softening")
Asthma	Overweight
Autism/Asperger's	Rheumatoid Arthritis
Cancer **(list type)**	Seizures/Epilepsy
Congenital Heart Disease	Sudden Infant Death (SIDS)
Coronary Artery Disease	Stroke/Cerebrovascular Accident
Depression	Sudden Cardiac Death
Diabetes	Thyroid Disease
Drug/Substance Abuse	Ureteral/Kidney Reflux
Food Allergies	Other Concerns/Issues
HIV/AIDS	

Reviewed by MD_____

Broadway Medical Clinic, LLP (BMC)
Consents, Releases, and Agreements

Patient Name	Date of Birth

Notice of Uses and Disclosures of Protected health Information

I acknowledge that I have been provided with BMC Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of bills, or in the performance of health care operations of BMC as well as my individual rights and the duties of BMC with respect to my protected health information.

I understand that BMC may use or disclose my protected health information to diagnose or provide treatment for me, to obtain payment for health care expenses, or to conduct health care operations. "Protected health information" includes information created, maintained, or received by BMC that identifies me, or from which my identity could be determined, and which relates to my past, present, or future physical or mental health, condition, treatment, or payments for medical services.

BMC reserves the right to change the privacy practices that are described in its notice of Privacy Practices. BMC will post any revised Notice of Privacy Practices in its office. In addition, I may obtain a revised Notice of Privacy Practices by contacting BMC and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient/Guardian Signature	Date

Financial Agreement and Assignment of Benefits:

Medicare & Medicaid: I request that payment under the medical insurance program be made either to me or to Broadway Medical Clinic (BMC) on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim.

All other Payors: I authorize payment directly to BMC of all benefits otherwise payable by any insurance policy(s) and I hereby irrevocably assign such benefits to BMC in an amount not to exceed the charges for services rendered.

I agree to be financially responsible for the balance left after processing by my insurance. If not covered by insurance, I agree to be financially responsible for services rendered. If I am unable to pay in full, I understand that a payment plan may be established.

Patient/Guardian Signature	Date