valley MED
@ the ten
FAMILY & GENERAL PRACTICE

www.valleymedpc.com
10 Coburg Road, Suite 201
Eugene, OR 97401
P: 541-687-8581
F: 541-343-1411

Hello _____,

Welcome to Valley Med @ the ten! We look forward to caring for you!

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.
- ✓ Help you play an active role in your health.

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

We 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. Your team is led by your primary care provider.

Brittany Alloway, DO
Damon Armitage, MD
Laurel Merz, FNP
Ralph Taguba, PA
McKenzie Watts, FNP

Please review the entire packet and complete the enclosed forms. Remember to bring your current insurance card, a form of payment, and an up to date list of medications and supplements.

If you have questions regarding your appointment or this packet, please contact us at 541-687-8581. We invite you to visit our website at www.valleymedpc.com, where you can find more information about our providers and services.

We look forward to meeting you at your upcoming appointment scheduled on:

_____

Clinic hours are from 8:30 am -5:00 pm

If you are having a life-threatening emergency, please call 911. If you are experiencing a non-life-threatening medical issue and need to contact the clinic after hours please call the office number at 541-687-8581 and our answering service will connect you to the on-call physician.

Please contact your pharmacy for all prescription refills that do not have to be picked up in the office. If your Rx bottle indicates you are out of refills the pharmacy will send us a request to authorize additional refills. Please allow 48-72 business hours for your refill to be processed. If you are due for a follow-up appointment please call the office to schedule.

Please call us at least 24 hours ahead of time to cancel or reschedule your appointments. This will give us time to give the appointment slot to another patient who needs care. As specified in our financial policy there will be a $100.00 charge for failure to show for a scheduled appointment or cancelling with less than 24 hours notice.

It is necessary for our medical staff to prioritize callbacks by addressing the most medically necessary calls first. We receive a lot of phone calls daily and try our best to answer them in a timely manner. The providers make most of their calls during lunch and after hours. Your call should be returned the day you call, however if you do not receive a call back in what you feel is a reasonable amount of time, please call again. Please remember the patient portal is for non-urgent communication only and a response should be returned within 48 hours.

We use an automated system to remind you of your appointments, and to inform you when a prescription has been sent to the pharmacy. A voice message will be sent as well as a text message reminder. If you answer your phone you can confirm your appointment by staying on the line. If you need to reschedule we ask you to call the office, and we would be happy to assist you.

Valley Med has a secure patient portal. You can send messages, review appointment times, see referral updates, receive patient education, lab results, visit summaries and more.

Onsite or telephonic interpretation services are available upon request.

Under law patients who don't have insurance or who are not using insurance have the right to receive a “Good Faith Estimate” explaining how much their care will cost. You have rights to dispute the charge if the bill is significantly more. For more information visit: https://www.cms.gov/nosurprises

If you've had a change in insurance since originally scheduling, please contact our office. Valley med is currently at capacity for Medicare and Medicaid patients and not accepting new patients with these insurance plans unless they are already established with our clinic.

We encourage you to visit our website at www.valleymedpc.com for more details regarding our office programs and policies.

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.

We take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We are dedicated to defending your right to a confidential relationship with your provider.

This notice describes how your medical information may be used and disclosed and how you can access this information. Please review it carefully.

How We May Use and Disclose Your Information

We may use and disclose health information about you without your permission for the following reasons:

1. **For Treatment:** To coordinate or manage your care with other providers or facilities.
2. **For Payment:** To obtain reimbursement from insurance for services provided.
3. **For Healthcare Operations:** To improve our services, manage our practice, train staff, and perform audits.
4. **For Legal Requirements:** When required by federal, state, or local law.
5. **To Prevent Serious Threats:** To protect your health and safety or the health and safety of others.
6. **For Public Health and Safety:** Including disease prevention, abuse reporting, and FDA oversight.
7. **For Research:** When reviewed and approved under a special process.
8. **For Workers' Compensation and Law Enforcement:** When required under these programs.
9. **With Family or Friends:** If involved in your care and based on your preference or best interest.

We will only share the minimum necessary information needed for each purpose.

We will not use or disclose your health information for marketing, sale, or fundraising without your written authorization. You may revoke this authorization at any time in writing.

Special Protections: Substance Use Disorder (SUD) Records

If your medical record includes information related to substance use disorder treatment protected under federal law (42 CFR Part 2), that information has additional privacy protections:

- We will not disclose it without your written consent unless required by law.
- It may not be used in court or legal proceedings without a special court order.
- You may revoke your consent at any time.
- Any re-disclosure of this information by others may no longer be protected.
- You have the right to opt out of any fundraising communications.

Special Protections Under Oregon Law

Oregon law provides additional privacy protections for certain types of health information. These laws may limit how we use or disclose this information, even when disclosure would otherwise be permitted under federal law (HIPAA).

This includes:

- **HIV/AIDS and HIV testing information** (ORS 433.045), which may not be disclosed without your specific written authorization except as permitted by law.
- **Mental health treatment information** (ORS 179.505–179.509), which may have additional restrictions on use and disclosure.
- **Genetic information** (ORS 192.531–192.549), which is subject to special confidentiality protections.
- **Substance Use Disorder treatment records** protected under federal law (42 CFR Part 2), as described above.

Your Rights

You have the right to:

- **Access**: Ask to see or get a copy of your health and billing records.
- **Amend**: Ask us to correct your records if you think they're incorrect.
- **Request Restrictions**: Ask us not to use or share certain information. We are not required to agree but will consider your request.
- **Request Confidential Communications**: Ask us to contact you in a specific way (e.g., only at work, no voicemail).
- **Accounting of Disclosures**: Ask for a list of when we shared your information for reasons other than treatment, payment, or healthcare operations.
- **Get a Copy of This Notice**: You can request a paper copy at any time.
- **Be Notified of a Breach**: You will be notified if a breach occurs that may have compromised your protected health information.

To exercise any of these rights, contact our Privacy Officer using the details at the bottom of this page.

Our Responsibilities

We are required by law to:

- Keep your health information private.
- Provide you with this Notice.
- Follow the terms of this Notice.
- Notify you if a breach of your protected information occurs.

We may change our privacy practices and update this Notice. If we do, the new terms will apply to all health information we maintain. We will post the updated Notice in our office and on our website and make copies available upon request.

Complaints and Questions

If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Contact for complaints or more information:	Privacy Officer Valley Med at the Ten 10 Coburg Rd. STE 201, Eugene, OR 97401 541-687-8581

We are committed to earning and maintaining your trust by protecting your health information with care and respect.

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Financial Policy Acknowledgement

In the interest of a good health care practice, it is desirable to establish an office and credit policy to avoid misunderstandings. Our primary responsibility is to help our patients enjoy a positive experience and provide excellent health care.

- Patients will need to provide our office with their social security number and health insurance card (if applicable) unless the total charge is paid in cash at time of service. Treatment may be postponed if patient does not furnish the items above.
- All accounts balances are due at the time of the visit (this includes co-pay, deductible, or percentage not paid by insurance). There will be a fee of $10.00 for those who are unable to pay their co-pay at the time of service.
- A 20% discount is extended to patients with no insurance coverage, but only applies when the visit is paid in full on the same day of the service.
- Insurance is billed as a courtesy to our patients. It is the responsibility of the patient to verify demographic and insurance information at every visit, and to inform the clinic of any changes. Any questions or disputes about the insurance policy, for example what treatment is covered and the patients out of pocket expense, will need to be resolved by the patient directly with their insurance carrier. Ultimately, the patient is responsible for the timely payment of their account.
- A fee of $15.00 will be charged if payment is not made by the due date listed on patient statement. There will be a charge of $25.00 for any NSF returned check.
- There will be a $100.00 charge for a missed appointment or canceling with less than 24 hours notice. Multiple missed appointments may result in scheduling limitations (scheduling the day you wish to be seen only) or discharge from the practice. The initial consultation appointment missed or NOT canceled with **24 hour** notice may result in the inability to reschedule or establish care at our facility. Appointment reminders are sent as a courtesy; however, it is the sole responsibility of the patient to be aware of their appointment date and time.

I have read Valley Med's credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a collection agency and I may be charged a collection fee of up to $75.00. Also, if it becomes necessary to effect collections on any amount owed on this or subsequent visits; the undersigned agrees to pay for all costs and expenses, including attorney fees.

Print Patient Name Date

Responsible Party Signature

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Date: _____/_____/_____ **Date of Birth**____/____/____

Patient Name _____
First Last Middle Initial

Sex at Birth: Male □ Female □ **Social Security#:** _____-_____-_____

Gender Identity: Male □ Female □ Non-Binary □ Other_____

Mailing Address: _____

City:_____ **State:**_____ **Zip:**_____

Address (if different from mailing address) _____

Home Phone (land line only): (_____)_____ Ok to leave message? □

Cell Phone: (_____)_____ Ok to leave message? □

Emergency Contact: _____ _____ **(____)**_____
Name Relationship Phone Number

Marital Status: Single Married Divorced Widow Partner

Do you want a Valley Med secure patient portal account? Yes □ No □
If yes, we will email you with a username and temporary password. The patient portal allows you to view your health information safely and securely in your own home.

Email Address:_____

Employer:_____ **Work Phone** _____

Preferred Pharmacy/Location: _____

Mail Order Pharmacy:_____

Automated appointment reminders/pharmacy notification options:
Preferred Phone number: Home (land line only) □ Cell □
Preferred Language: English □ Spanish □ **Preferred Time to Call/Text**: Morning □ Afternoon □ Evening □

Race: *(*please select one only*) White Hispanic Asian African American or Black Native Hawaiian American Indian or Alaska Native Other Race Pacific Islander Unreported

Ethnicity: *(*please select one only*) Non-Hispanic or Latino Hispanic or Latino Unreported

Primary Language: _____ **Interpreter required? Yes □ No □**

HIPAA - Other than yourself, do you wish to give consent to share medical information with someone else? Yes □ No □

*It is the sole responsibility of the patient or guardian to inform Valley Med if you wish to change this consent in any way.

If Yes, Name: _____Phone:(_____)_____

For those with more than one insurance plan

It is important to "Coordinate Benefits" and ensure all plans are informed of one another. To avoid billing issues our billing office must know the correct order to submit your medical bills. Please review the general guidelines for double coverage.

- **Employee**- If you are employed, your employer sponsored plan is primary. Additional coverage through a spouse or parent would be secondary.
- **Dependent Child Covered Under More Than One Plan**- *The birthday rule* says that primary coverage comes from the plan of the parent whose birthday (month and day only) comes first in the year. *Longer/Shorter Length of Coverage*- If the previous rule doesn't apply, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second. **If you're not sure please check and call back to confirm.**
- **Medicaid-** A state sponsored plan is secondary to another insurance plan.

Insurance Information: *If the policy holder is someone other than the patient, please complete the following information* ***about them*** *in addition to providing a copy of the insurance card***.**

Primary Insurance - Co-pay $_____

Plan Name/Policy #:_____

Policy Holder's Information/Main Subscriber:

Name:_____

DOB: ____/____/____ S.S.# _____-_____-_____

Phone _____

Relationship to patient: _____

Secondary Insurance- Co-pay $_____

Plan Name/Policy #:_____

Policy Holder's Information/Main Subscriber:

Name:_____

DOB: ____/____/____ S.S.# _____-_____-_____

Phone _____

Relationship to patient: _____

Responsible Party Information ***STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY***

Name_____ Relationship to Patient _____

Mailing Address_____ City_____ State_____ Zip_____

DOB_____/_____/_____ S.S.#_____-_____-_____ Employer_____

I authorize the providers in the above-named clinic to treat the person whose name appears in the patient information section.

_____ _____

****Patient Signature/Guardian Party's Signature*** Date

I hereby authorize the above-named clinic to furnish the insured's insurance company all information it may request concerning my medical care. I hereby assign to the provider(s) all money to which I am entitled for expense(s) relative to the services performed from time to time, but not to exceed my indebtedness to said provider(s). I understand I am financially responsible to said provider(s) for charges not covered by this agreement.

_____ _____

****Patient Signature/Guardian Party's Signature*** Date

I have been offered Valley Med's privacy policy statement. ***Received*** ***Declined***

_____ _____

****Patient Signature/Guardian Party's Signature*** Date

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Name **Date of birth**

Comprehensive Adult New Patient Health History Questionnaire

If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it.

Who referred you to the practice?

Circle one: patient, family member, physician, assigned. Name?_____

Main reason for today's visit: _____

Other concerns: _____

_____

What are your health goals for the next year? _____

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

Please list healthcare providers & their specialty you see regularly: _____

_____

List any medical suppliers you use (e.g. respiratory supplies, etc): _____

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

□ Check box if you do not take any prescription or over the counter medications.
□ Check box if you brought a list of your medications (give it to my assistant and don't write in medications below).

Medication	Dose (e.g. mg/pill)	How many times per day?

ALLERGIES or intolerance to medications? □ **NONE**

(If yes, to what & what reaction?) _____

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have had.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot *or* illness _____ Pneumovax (pneumonia) _____

Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) Date _____ Result, if known _____

Cologuard or Colonoscopy (circle one) Date (year)_____ Abnormal? □ No □ Yes

Polyp? □ No □ Yes

Women only:

Mammogram Most recent date/where _____ Abnormal? □ No □ Yes

Pap Smear Most recent date/where _____ Abnormal? □ No □ Yes

Bone Density Test Most recent date/where _____ Abnormal? □ No □ Yes

PERSONAL MEDICAL HISTORY:

Condition	*Now*	*Past*	*Comments*

□ **Check box if you have no history of significant medical illnesses.**

SURGICAL & PROCEDURE HISTORY – Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	*Yes*	*Year*	*Comments*

□ **Check box if you have never had any medical procedures or surgeries.**

FAMILY HISTORY

Adopted? □ No □ Yes. If adopted and you do <u>not</u> know your family history skip the Family History section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents, brothers & sisters are the most important). Write in number of siblings in appropriate boxes.* If some siblings are alive and some are deceased use the space to the right to explain further.

	Mother	*Father*	** Sister(s)*	** Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	
Alive									
Deceased									
Age currently or at death									

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Mom's Mom*	*Mom's Dad*	*Dad's Mom*	*Dad's Dad*	*Other blood relatives (list relationship to you)*	*List age(s) at diagnosis if known and if this was the cause of death*
No significant history known										
Hypertension – high blood pressure										
Kidney Disorder										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes										
Cancer, /Type										
Stroke										

Tobacco Use:
Smoke or smoked: Cigarettes

□ Never □ Former □ Current

Exposure to second hand smoke? □ No □ Yes

(If never used any tobacco can skip to Alcohol Use section below)

Current smoker: Packs/day: _____ # of years: _____

Former smoker: Quit date: _____

Approximately how many packs/day did you smoke? _____

How many years did you smoke? _____

Other tobacco? (circle) Snuff / Chew / Pipe / Cigar

Quit date _____ Current Use? □ Yes

Are you ready to quit? □ No □ Yes

Alcohol Use:
Do you drink alcohol? □ No □ Yes

# of drinks/week: _____ □ Beer □ Wine □ Liquor

How many times in a year have you had >4 drinks in a day? _____

Drug Use:

Have you **ever** used recreational drugs? □ No □ Yes

If yes, which ones? _____

Quit which ones? □ All _____

Any used currently? _____

Sexual Activity:

Are you sexually involved: □ Not currently □ Never □ Yes

Sexual partner(s) is/are/have been/may be in future:
□ male □ female

Birth control method or STD prevention (check all that apply):
□ None needed □ Condom □ Pill □ IUD □ Patch □ Ring
□ Diaphragm □ Vasectomy □ Tubal ligation
□ Other method
(specify):_____

Diet:

Do you follow a special diet? □ No □ Yes

vegetarian, vegan, gluten free, other _____

Mood

In the past 2 weeks: Have you been feeling down, depressed or hopeless? □ No □ Yes

Do you have little interest or pleasure in doing things? □ No □ Yes

SOCIAL DOCUMENTATION:
Name you prefer we use when contacting you (nickname, first, or last with Mr, Mrs, Ms, etc): _____

Country of birth: _____

Who lives at home with you: □ No one □ Spouse/partner □ Children _____

□ Pets (what type) _____ □ Other (roommates, extended family, etc) _____

Marital status: □ single □ partner □ married □ divorced □ widowed

Spouse/partner's name: _____

Number of children: _____ Ages (if minors): _____ # of grandchildren: _____ # of great grandchildren: _____

Please list your interests, hobbies, group involvement, volunteer work, and/or travel outside of country in the past 6 months:

SOCIOECONOMIC:

Occupation (or prior occupation): _____ Employer: _____

If you are not currently working, you are: □ retired □ unemployed □ on a leave of absence □ disabled □ homemaker

□ other _____

Education: □ high school or GED □ trade school □ college □ graduate school □ other _____

Are you worried that in the next 2 months, you may not have stable housing? □ No □ Yes

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? □ No □ Yes

In the last 12 months, have you ever had to go without health care because you didn't have a way to get there? □ No □ Yes

If you checked Yes to any of the three boxes above, would you like information about assistance with any of these needs?

□ No □ Yes

MEDICAL FORMS:

Please check any of the following forms you have completed:

- □ Advance Directive for Health Care (ADHC)
- □ Durable Power of Attorney (DPA) for healthcare decisions
- □ Living Will
- □ POLST (Physician Orders for Life Sustaining Therapy)
- □ Know about these or have the forms but have not completed them
- □ Don't know what these are

REPRODUCTIVE HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____ Number of abortions: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ □ Not applicable

Do you have concerns about your periods or menopause you'd like to discuss? □ No □ Yes

If you are having periods, how often do they occur? Every _____ days. How long do they last? _____ days.

Thank-you for taking the time to complete this form!