



# CGFM Financial Policies

1750 12th Street  
Hood River, OR 97031

Phone: 541-386-5070  
Fax: 541-386-7190  
Web: www.cgfm.com

**Date:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy)

**Patient Name:** \_\_\_\_\_  
(last name, first name, middle initial)

Thank you for choosing Columbia Gorge Family Medicine (CGFM) for your healthcare services.

Please review the policies below carefully and feel free to ask questions should you have them. In order to ensure accurate billing and to prevent fraud, we ask each patient to provide us a copy of a photo ID along with their insurance card. When you receive a new insurance card or change to another health plan, it is your responsibility to inform us with updated policy info and provide us with a copy of the card

We bill your insurance as a courtesy and must have accurate health plan information. This includes primary and secondary, automobile and workers' compensation insurances. Failure to provide us with accurate and up-to-date information specific to your visit will result in patient responsibility for the balance owed.

It is the patient's responsibility to check with their health plan for eligibility and benefit details including: 1) In-network provider status; 2) Primary Care Provider (PCP) assignment; and 3) potential financial responsibility for services not covered on or after the date of service at CGFM. **By signing below, I accept this responsibility.**

Most office visits require a co-pay which is due at the time of service. If your co-pay is not printed on your card and/or we are unable to confirm when checking eligibility, a standard deposit of \$25 will apply.

If you don't have health insurance, have a high deductible plan or your account is in collection status, we require a \$75.00 deposit every visit. Your \$75 deposit will be applied to your total out of pocket.

For visits during extended hours (Acute Care) we collect \$100 at the time of service if uninsured. We will bill your insurance and if payment is made we will refund any monies owed to you. If you are an established patient we will collect based on your insurance plan's estimated patient responsibility, otherwise a \$50 deposit will be collected.

Patients without health insurance (self-pay) will receive a 10% "uninsured discount". The uninsured discount is applicable to professional services only and doesn't apply to drugs, vaccines, or medical supplies. The uninsured discount will only apply to services when Patient was truly uninsured and will be reversed if we discover active health insurance or a health plan retroactively covers patient visit.

Please inquire with our billing staff about 10% pay in full discount or payment plan options.

There is a \$30 charge on returned checks. Failure to pay your bill or make arrangements with our billing department could result in dismissal from the practice and your account being assigned to an outside collection agency where you will be responsible for all collection cost and attorney fees incurred.

Missing your appointment without calling us to cancel or reschedule prior to 24 hours will result in a \$25 fee. After three (3) no-shows, your account will go to review for dismissal.

I understand and agree to Columbia Gorge Family Medicine's financial policies as described above.

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of patient

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of parent, guardian, or legal representative

# Patient Demographics



**COLUMBIA GORGE**  
FAMILY MEDICINE

**Date:** \_\_\_\_\_  
(mm/dd/yyyy)

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**Patient Name:** \_\_\_\_\_  
(last name, first name middle initial)

**Birthdate:** \_\_\_\_\_  
(mm/dd/yyyy)

**Sex:**  Female  
 Male

**Previous Name:** \_\_\_\_\_  
(e.g., maiden name)

## Home Address

\_\_\_\_\_ Address

**Preferred Name:** \_\_\_\_\_  
(e.g., nickname)

\_\_\_\_\_ **Mailing Address**

\_\_\_\_\_ City, State \_\_\_\_\_ Zipcode

## Patient Contact Information

Home phone: \_\_\_\_\_ (Please include area code)  
Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_

**Marital status:**  Single  Married  
 Separated  Divorced  
 Widowed

## Secure Web Portal Access

If you would you like to have access to our portal, please check in at the front desk for your log-in and password.

## Emergency Contact Information

**Name:** \_\_\_\_\_  
(last name, first name middle initial)

**Relationship:** \_\_\_\_\_

Home phone: \_\_\_\_\_ (Please include area code)  
Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_

## Other Contact Information

**Name:** \_\_\_\_\_  
(last name, first name middle initial)

**Relationship:** \_\_\_\_\_

Home phone: \_\_\_\_\_ (Please include area code)  
Work phone: \_\_\_\_\_  
Cell phone: \_\_\_\_\_

## Detailed Voicemail Message Consent

Can Columbia Gorge Family Medicine leave detailed messages about your appointments, lab results, or conditions on your Phone Voicemail to avoid multiple call attempts?  YES  NO

### Race

- American Indian or Alaska Native
- Asian
- Native Hawaiian
- Black or African American
- White
- Hispanic
- Other

### Ethnicity

- Hispanic
- Non-Hispanic

### Preferred Language

- English
- Spanish
- Other: \_\_\_\_\_

Check here if you to decline to answer:

# Insurance Information



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**Date:** \_\_\_\_\_  
(mm/dd/yyyy)

**Name:** \_\_\_\_\_  
(last name, first name middle initial)

## Primary insurance carrier :

\_\_\_\_\_  
Primary insurance name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State                      Zipcode

\_\_\_\_\_  
Phone number

## Secondary insurance carrier :

\_\_\_\_\_  
Primary insurance name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State                      Zipcode

\_\_\_\_\_  
Phone number

## Subscriber information:

\_\_\_\_\_  
Subscriber name (last name, first name middle initial)

\_\_\_\_\_  
Subscriber date of birth (mm/dd/yyyy)

## Subscriber information:

\_\_\_\_\_  
Subscriber name (last name, first name middle initial)

\_\_\_\_\_  
Subscriber date of birth (mm/dd/yyyy)

**Subscriber number:** \_\_\_\_\_

**Subscriber number:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_

# Consent for Treatment

IMPORTANT: To be filled out by patient if 14 years or older



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## CONSENT FOR TREATMENT:

I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physicians. This consent is valid until such time it is revoked in writing or a new consent is completed.

## RELEASE OF INFORMATION:

By signing this form, you are granting consent to Columbia Gorge Family Medicine to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices is available at the front desk and also our website, www.cgfm.com. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 541-386-5070. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request and we are bound by this agreement.

## MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

## ASSIGNMENT OF BENEFITS:

I hereby authorize my insurance benefits be paid directly to Columbia Gorge Family Medicine. I understand I am financially responsible for non-covered services, any remaining deductible and co-pay. I also authorize Columbia Gorge Family Medicine to release any information required in the processing of this claim.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent. The date effective of a written revoked consent will be the date it is received and scanned into the patients chart.

## PRESCRIPTION DATA:

I authorize Columbia Gorge Family Medicine to obtain information regarding my prescriptions from pharmacies and other outside sources to better coordinate my healthcare.  Yes  No

## REVOCAION RIGHTS:

I hereby consent to the authorizations described above and will accept medical treatment from Columbia Gorge Family Medicine. This authorization will stay in effect until such time a new one is signed or a written revocation is done.

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of patient

**Signed** \_\_\_\_\_ **by** \_\_\_\_\_  
(mm/dd/yyyy) Signature of parent, guardian, or legal representative

**Parent / Guardian / Representative Name (Printed):** \_\_\_\_\_

Any person listed below has my permission to authorize medical treatment for me/this patient. These same people have the right to discuss my health care with representatives of the practice for purposes of treatment, billing, or health care operations.

**1) Name:** \_\_\_\_\_  
Please PRINT name and relationship to patient Phone Number

**2) Name:** \_\_\_\_\_  
Please PRINT name and relationship to patient Phone Number

**3) Name:** \_\_\_\_\_  
Please PRINT name and relationship to patient Phone Number

# Medical History



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## Medical Problems

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Hospitalizations

 Why were you hospitalized? When? Where?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## List all medications you are currently taking and how often you take them.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**Do you have any allergies?**  No  Yes \_\_\_\_\_  
(Please list any allergies)

## Please list family members, their relation to you, and anyone else living with you.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

## Patient Social History:

Marital status:  Single  Married  Separated  Divorced  Widowed

Use of alcohol:  Never  Quit  Yes How much? \_\_\_\_\_

Use of tobacco:  Never  Quit  Yes How much? \_\_\_\_\_

Use of street drugs:  Never  Quit  Yes What kind and how often? \_\_\_\_\_

Is there anything about your living situation that we should know? \_\_\_\_\_

## Family History

 Does your family have a history of Cancer, Diabetes, Heart disease, Glaucoma, Melanoma, or other major medical problem?

Mother: \_\_\_\_\_ Father: \_\_\_\_\_ Sibling 1: \_\_\_\_\_

Maternal Grandmother: \_\_\_\_\_ Paternal Grandmother: \_\_\_\_\_ Sibling 2: \_\_\_\_\_

Maternal Grandfather: \_\_\_\_\_ Paternal Grandfather: \_\_\_\_\_ Sibling 3: \_\_\_\_\_

Other family medical history: \_\_\_\_\_ Sibling 4: \_\_\_\_\_

## Adult Women's Health

 (For female patients only)

Last menstrual period: \_\_\_\_\_ Number of pregnancies: \_\_\_\_\_ Date of last Pap: \_\_\_\_\_

First menstrual period: \_\_\_\_\_ Number of live births: \_\_\_\_\_ History of abnormal Pap? \_\_\_\_\_

Current birth control: \_\_\_\_\_ Complications: \_\_\_\_\_ Date of last mammogram: \_\_\_\_\_