OREGON UROLOGY ALLIANCE
19260 SW 65th Ave. Suite 310 Tualatin, OR 97062
Phone: 503-692-1200 **Fax:** 503-692-1220

Please arrive **15 minutes before** your scheduled appointment time.
Please bring the following items to your appointment:

- Completed paperwork (attached)
- Photo ID and Insurance Card
- List of your prescription and non-prescription drugs
- List of medical conditions
- Be prepared to provide a urine specimen

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Demographic Information		
Patient Name:		Preferred Name/Nickname:
Mailing Address:		
City:	State:	Zip Code:
Email Address:		Web enable? ☐ Yes ☐ No
Phone:	Date of Birth:	Gender:
Emergency Contact Name:		Phone:
Relationship:		

Insurance Information	
Primary Insurance:	Phone Number:
Subscriber Name:	Date of Birth:
Subscriber ID:	Group #:
Secondary Insurance:	Phone Number:
Subscriber Name:	Date of Birth:
Subscriber ID:	Group #:

Care Team Information	
Referring Dr:	Primary Care Dr:

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Preferred Pharmacy:	Pharmacy Phone Number:

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Patient's Name:	**Height:**	**Weight:**

Do you currently have or have you had the following in the last 6 months? *Please check Yes or No*

Weight Loss	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No	History of Pneumonia	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Prior Stroke	☐ Yes ☐ No	History of Tuberculosis	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Difficulty Swallowing	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Blood in Stools	☐ Yes ☐ No
Poor Appetite	☐ Yes ☐ No	Palpitations	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Headache	☐ Yes ☐ No	Cough	☐ Yes ☐ No	Back Pain	☐ Yes ☐ No

Please describe any other current health problem not listed above:

Surgeries:	**Date of surgery:**

Allergies:	**Reaction:**

Medication:	**Dosage:**	**Frequency:**

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Social History			
Do you currently Smoke/Chew Tobacco?	□Yes □No	If No, have you in the past?	□Yes □No
How many years have you used tobacco?		How many packs per day?	
Do you drink alcohol, beer or wine?	□Yes □No	In the past?	□Yes □No
Number per week?			
Do you currently drink coffee or tea?	□Yes □No	If yes, how many cups per day?	

Family History						
Relative	Age if Living	Age at Death	Cancer	Diabetes	Heart Disease	High Blood Pressure
Mother						
Father						
Sibling						
Sibling						

BILLING POLICIES AND AGREEMENT

We will bill your insurance company as a courtesy to our patients and will do our best to help you understand the coverage your insurance policy provides. It is important to understand that your policy may not cover all of the allowed charges and claims are ultimately the patient's responsibility. We are happy to work with you to make it easier.

Co-pays are expected at the time of service and account balances are due within 30 days of the statement date. Some elective procedures may require a deposit or payment in full prior to surgery. If you need to make payments arrangements, please contact our billing office. If partial payment amounts are less than $50/month, or you need more than six months to pay off the balance, you may receive a $15/month billing fee.

Please bring your insurance cards to each appointment. Without proof of insurance coverage, we may ask you for a deposit or we may have to reschedule your appointment.

If the balance in full, or a mutually agreed payment agreement, or a failed payment agreement has not been cured within 60 days of the statement/demand for payment, your account could be referred to our outside collection agency.

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*Should your account be referred to our outside collection agency, you could be liable, under this contract, for out-of-pocket collection cost in the amount of **45%** of your unpaid balance at the time of assignment. In addition, should litigation actions be taken by the agency and the agency prevails, you could be held liable for litigation fees as well. Also, be aware the agency has the right to credit report any and all unpaid balance(s) per their Credit Reporting guidelines.*

We offer a 25% discount for uninsured patients. You may be asked to pay a $100 deposit at time of service. Please be aware that you will be responsible for the remaining balance of charges. This discount may not apply to elective procedures. Please contact our business office at (503) 783-0208 to inquire.

CANCELLATION / NO SHOW POLICY

We ask that you call our office at least 48 hours in advance of a cancellation or reschedule. We understand that there may be unavoidable situations that arise, but repeated issues with keeping appointments may result in dismissal from the practice. You may be billed $75 for a late cancellation or no-show appointment.

By signing below, I agree to the above policies.

_____ _____

Print Name of Patient (or Representative) **Signature of Patient (or Representative)**

_____

Date

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ACKNOWLEDGEMENT, CONSENT and HIPAA AGREEMENT

I understand that the office of Oregon Urology Alliance (referred to below as "The Practice) will use and disclose health information about me. I understand that my health information may include information both created and received by The Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions, and similar types of health-related information.
I understand and agree The Practice may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to, consult with, and manage along with other health care providers for my care and treatment
- Determine eligibility for insurance coverage, submit claims and other related information for payment
- Perform various office and administrative functions that support my physician's efforts to provide me with, and be reimbursed for, quality, cost-effective health care.

I understand that I have the right to receive and review a written description of how The Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the policies followed by the employees, staff and other office personnel of The Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of The Practice's Notice of Privacy Practices in effect will be posted in the reception area.
I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that The Practice is not required by law to agree to such requests.

Without your approval, we cannot release any medical information to spouses, family or friends. Please list the names of those you would like listed as being involved in your healthcare, as well as any restrictions regarding their involvement. This information can be changed or revoked with your permission at any time.

Name: _____ DOB: _____

Relationship: _____ Phone: _____

Restrictions: _____

Name: _____ DOB: _____

Relationship: _____ Phone: _____

Restrictions: _____

By signing below, I agree that I have reviewed and understand the above information.

_____ _____

Patient (or Representative and relationship to patient) **Date**

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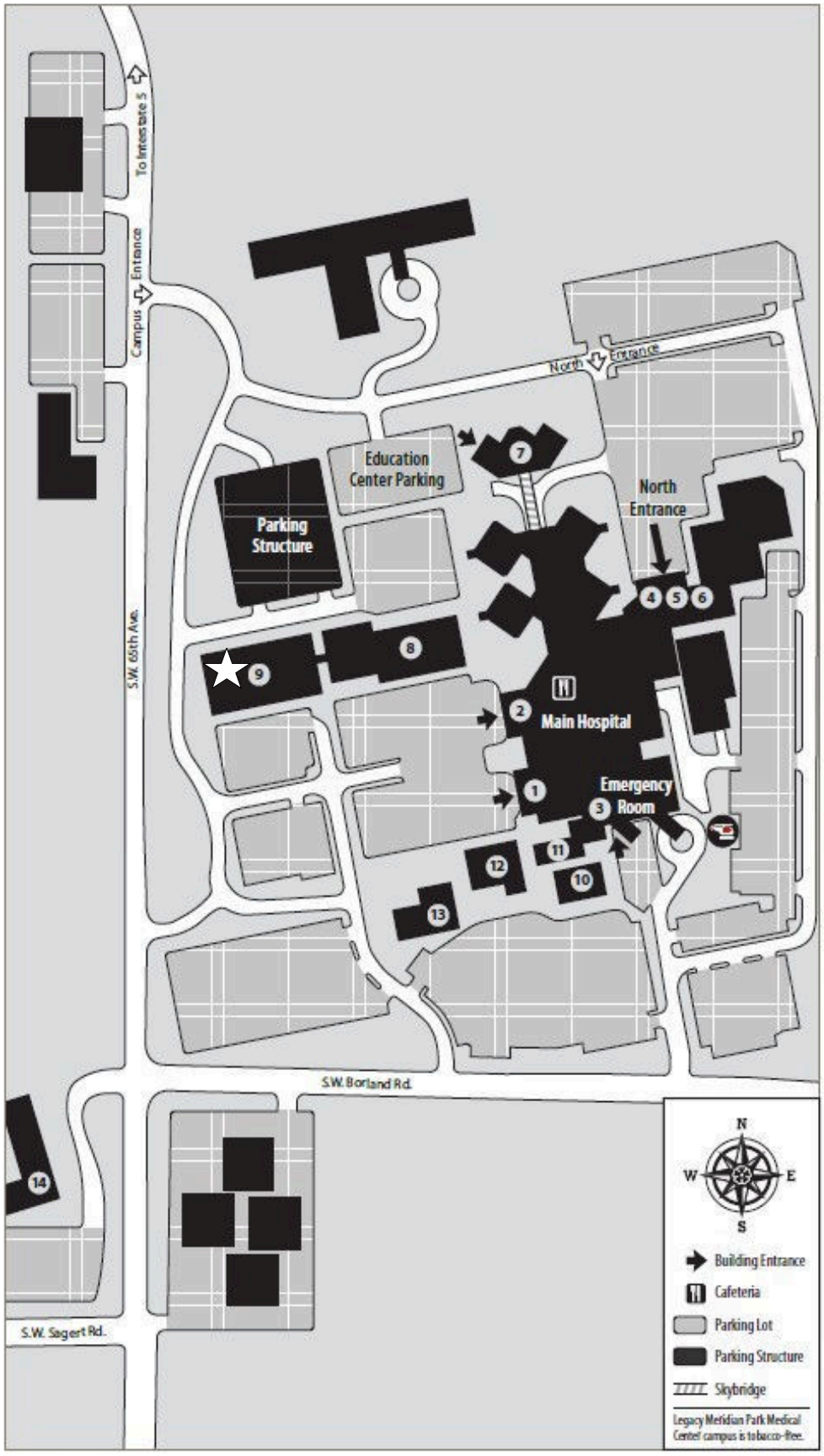
We are located on the campus of Legacy Meridian Park Hospital
In Medical Plaza 2 on the 3rd floor, Suite 310



LEGACY HEALTH

Legacy Meridian Park Medical Center
19300 S.W. 65th Ave.
Tualatin, OR 97062
503-692-1212
www.legacyhealth.org

1 **Main Entrance**
19300 S.W. 65th Ave.
2 **Patient Pick Up**
3 **Emergency Room**
4 **North Entrance**
5 **Family Birth Center**
6 **Intensive Care Unit**
7 **Health Education Center**
8 **Medical Plaza 1**
19250 S.W. 65th Ave.
9 **Medical Plaza 2**
19260 S.W. 65th Ave.
10 **Anticoagulation Clinic; Diabetes and Nutrition Clinic; Genetics; Wound, Ostomy and Skin Services**
6475 S.W. Borland Road
11 **Cardiac Rehabilitation**
12 **Physician Offices**
6485 S.W. Borland Road
13 **Meridian Park Radiation Oncology Center**
6489 S.W. Borland Road
14 **Legacy Tualatin Medical Building**
19875 S.W. 65th Ave.