541-747-4300
Springfield Family Physicians – Centennial Clinic – McKenzie Valley Primary Care

Welcome to Springfield Family Physicians!

We are honored you have chosen us as your healthcare provider and are thrilled to welcome you as a new patient.

For over 40 years, we have remained proudly independent, providing excellent Family Medicine to the community. With three convenient locations—all recognized as Tier 5 Patient-Centered Primary Care Homes—you can count on us for accessible, affordable, and high-quality care delivered through a collaborative, team-based approach.

Our team includes physicians, physician associates, nurse practitioners, clinical pharmacists, and integrated behavioral health providers, all working together to offer you the best primary care experience in town.

Your First Appointment
Thank you for scheduling your first visit with us! To help make your check-in smooth and efficient, please:

- Complete the enclosed new patient paperwork.
- Bring the completed forms, your current insurance card, and a photo ID to your appointment.
- Plan to arrive at least 10 minutes early for check-in.

Stay Connected With Us
Inside your welcome packet, you will find information about our online patient portal and Klara, our secure texting system. We believe great healthcare is built on strong communication, and our digital tools help support that partnership. Through the portal or app, you can view your health records, send secure messages to our team, and request appointments—anytime, from anywhere.

If you have any questions or would like help signing up for the patient portal, feel free to call us at **(541) 747-4300**. We're happy to assist.

We look forward to partnering with you in your health and wellness journey.

Warm regards,
The Springfield Family Physicians Team

SPRINGFIELD
FAMILY PHYSICIANS

541-747-4300
Springfield Family Physicians – Centennial Clinic – McKenzie Valley Primary Care

MEDICAL HISTORY FORM

Patient Name (please print): _____ Date: _____

Date of Birth: _____ Sex at Birth: ☐ Male ☐ Female Pronouns: _____

Gender Identity: ☐ Man ☐ Woman ☐ Nonbinary ☐ Transgender ☐ Other: _____

Occupation: _____ Previous Occupations: _____

PERSONAL HISTORY

ALLERGIES TO MEDICATIONS

1. _____
2. _____
3. _____

MEDICATIONS (*list all including over the counter medications/supplements*)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

HOSPITALIZATIONS and SURGERIES	YEAR
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

IMMUNIZATION HISTORY

Pneumonia Vaccine ☐ Yes ☐ No Date _____
Shingles Vaccine ☐ Yes ☐ No Date _____
Covid Vaccine ☐ Yes ☐ No Date _____
Tetanus Vaccine within 10 years Date_____

PERSONAL HABITS

Exercise: Type _____ How often? _____
Do you drink caffeine? ☐ Yes ☐ No
Number of cups per day? _____
How many hours of sleep per day? _____

PERSONAL and FAMILY HISTORY (*please list relation and age at the onset of the diagnosis*)

	SELF	RELATION/AGE
If deceased, age at death	☐	_____
Alcoholism	☐	_____
Asthma	☐	_____
Cancer	☐	_____
Bleeding/Clotting problems	☐	_____
Diabetes	☐	_____
Epilepsy	☐	_____
Gout	☐	_____
Heart disease	☐	_____
High blood pressure	☐	_____
Depression	☐	_____
Rheumatism/arthritis	☐	_____
Thyroid condition	☐	_____
Stroke	☐	_____

CURRENT HEALTH CONCERNS

1. _____
2. _____
3. _____
4. _____
5. _____

SMOKING HISTORY

Have you ever smoked? ☐ Yes ☐ No
☐ Cigarettes ☐ Pipe ☐ Chewing tobacco
If you smoked in the past, what year did you quit?
_____

Name:

Date:

PERSONAL HISTORY

Please mark an X in the appropriate blank spaces

	*Have this problem **now***	*Had this problem **previously***
1. Stiffness, muscle, or joint pain	_____ Yes _____ No	_____ Yes _____ No
2. Swollen joints	_____ Yes _____ No	_____ Yes _____ No
3. Back or shoulder pain	_____ Yes _____ No	_____ Yes _____ No
4. Pain in your feet	_____ Yes _____ No	_____ Yes _____ No
5. Skin problems	_____ Yes _____ No	_____ Yes _____ No
6. Changing moles or skin spots	_____ Yes _____ No	_____ Yes _____ No
7. Trouble stopping cuts from bleeding	_____ Yes _____ No	_____ Yes _____ No
8. Unexplained bruises or sores	_____ Yes _____ No	_____ Yes _____ No
9. Dizziness, fainting, or lightheaded	_____ Yes _____ No	_____ Yes _____ No
10. Numbness	_____ Yes _____ No	_____ Yes _____ No
11. Seizures or convulsions	_____ Yes _____ No	_____ Yes _____ No
12. Shakiness or tremors	_____ Yes _____ No	_____ Yes _____ No
13. Significant headaches	_____ Yes _____ No	_____ Yes _____ No
14. Death of a family member this year	_____ Yes _____ No	_____ Yes _____ No
15. Sleep problems or insomnia	_____ Yes _____ No	_____ Yes _____ No
16. Nervousness, anxiety, or irritability	_____ Yes _____ No	_____ Yes _____ No
17. Memory or concentration problems	_____ Yes _____ No	_____ Yes _____ No
18. Depression or loneliness	_____ Yes _____ No	_____ Yes _____ No
19. Sexual problems	_____ Yes _____ No	_____ Yes _____ No
20. Suicidal thoughts	_____ Yes _____ No	_____ Yes _____ No
21. Unexplained weight gain or loss	_____ Yes _____ No	_____ Yes _____ No
22. Appetite problems	_____ Yes _____ No	_____ Yes _____ No
23. Overly thirsty	_____ Yes _____ No	_____ Yes _____ No
24. Heartburn	_____ Yes _____ No	_____ Yes _____ No
25. Constipation	_____ Yes _____ No	_____ Yes _____ No
26. Feelings of being too hot or cold	_____ Yes _____ No	_____ Yes _____ No
27. Nausea or vomiting	_____ Yes _____ No	_____ Yes _____ No
28. Diarrhea or rectal bleeding	_____ Yes _____ No	_____ Yes _____ No
29. Frequent urination	_____ Yes _____ No	_____ Yes _____ No
30. Painful urination	_____ Yes _____ No	_____ Yes _____ No
31. Bladder leaks when coughing	_____ Yes _____ No	_____ Yes _____ No
32. Eye problems	_____ Yes _____ No	_____ Yes _____ No
33. Hearing problems	_____ Yes _____ No	_____ Yes _____ No
34. Tooth or mouth pain	_____ Yes _____ No	_____ Yes _____ No
35. Coughing or wheezing	_____ Yes _____ No	_____ Yes _____ No
36. High blood pressure	_____ Yes _____ No	_____ Yes _____ No
37. Heart murmur	_____ Yes _____ No	_____ Yes _____ No
38. Chest pain or pressure	_____ Yes _____ No	_____ Yes _____ No

REPRODUCTIVE HEALTH HISTORY

Please answer all that apply

1. Swelling, lumps, or pain in your testicles/penis _____ Yes _____ No
2. Prostrate problems, slow or weak urine stream _____ Yes _____ No
3. Discharge or burning from your penis _____ Yes _____ No
4. Last colonoscopy Date: _____ Provider/Location: _____
5. Vaginal discharge _____ Yes _____ No
6. Irregular menstrual periods _____ Yes _____ No
7. Lumps or pain in your breasts _____ Yes _____ No
8. Hysterectomy/Vasectomy _____ Yes _____ No *Age at the time of surgery: _____
9. Date of your last pap test _____
10. Date of your last period _____
11. Number of pregnancies _____
12. Number of live births _____
13. Method of birth control _____
14. Last mammogram: Date: _____ Location: _____

541-747-4300

Springfield Family Physicians – Centennial Clinic – McKenzie Valley Primary Care

NOTICE OF PRIVACY PRACTICE RECEIPT

Our Notice of Privacy Practices (NPP) provides information on how our practice may use and/or disclose protected health information about you for treatment, payment, and how you can get access to this information.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices. I understand that a copy can be found on the website at https://www.nwmedicalhomes.com/or at the front check-in desk upon request.

Patient Name (Printed) _____

Patient Signature _____

Patient Date of Birth _____

Today's Date _____

If signed by a personal representative.

Name of representative (printed) _____

Signature of Representative _____

Relationship to Patient _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Receipt of Notice of Privacy Policy, but was unable to do so as documented below.

Date	Staff Initials	Reason
		Refused to sign Other:

SPRINGFIELD
FAMILY PHYSICIANS

PATIENT REGISTRATION

PATIENT INFORMATION			
Last Name:	First Name:	Middle Initial:	Previous Name (if applicable):
Date of Birth:	Sex: ☐ Male ☐ Female ☐ Other:		Pronouns:
Mailing Address:			
City/Sate/ Zip:			
Home Phone:	Cell Phone:	Preferred method of contact for reminder calls and other electronically generated messages ☐ Voice ☐ Text If voice, select preferred number ☐ Home ☐ Cell	
SSN#:		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Occupation:		Email:	
Spouse/Partner:		Date of Birth:	
Employer:		Work Telephone#:	
Notify this person in case of emergency: ☐ Yes ☐ No			
If no, who should we notify?			
Relationship:		Telephone Number:	
RESPONSIBLE PARTY – If the patient is a minor or has a POA, the parent or guardian bringing the patient in will be listed as the guarantor			
Last Name:		First Name:	
Date of Birth:	SSN#:	Telephone#:	
Mailing Address (if different than above):			
Employer:		Employer Telephone #:	
ADDITIONAL INFORMATION (Please fill out all sections below)			
Can we leave a message regarding your medical care and test results? ☐ Yes ☐ No If yes, is it okay to leave a (select one) ☐ brief or ☐ detailed message.			
Preferred language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other (please specify)			
Race (please select): ☐ Caucasian ☐ Italian ☐ Asian ☐ Pacific Islander ☐ African American ☐ Native American ☐ Other ☐ Decline to Specify		Ethnicity (please select one): ☐ Hispanic ☐ Non- Hispanic ☐ Decline	
INSURANCE INFORMATION			
Primary Medical Insurance		Secondary Medical Insurance	
Ins. Co. Name:		Ins. Co. Name:	
Insured's Name: DOB:		Insured's Name: DOB:	
ID#:		ID#:	
Group #:		Group #:	

- I authorize SFP to release any medical information to my insurance carrier or third-party payor to facilitate processing my insurance claims. I understand that I am responsible for any charges of non-covered services.
- I authorize payment of authorized benefits due be paid directly to SFP.
- I understand that some charges may be denied by Medicare, and I will be responsible for payment with a signed advanced beneficiary notice.
- I understand that any electronic communication that I have authorized above may not be secure and there is a risk that a third party may read them.

Signature of Responsible Party: _____ Date: _____

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Springfield Family Physicians – Centennial Clinic – McKenzie Valley Primary Care

SPRINGFIELD FAMILY PHYSICIANS FINANCIAL POLICY

Thank you for choosing Springfield Family Physicians as your primary care provider. We are committed to building a successful provider-patient relationship with you and your family, providing quality and afford ab le healthcare. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Your care is a team effort, our staff will work together with you, both financially and medically, to ensure you a healthy, h appy life. Please ask if you have any questions about our fees, policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes.

PATIENT INFORMATION

All patients at Springfield Family Physicians must fill out a patient information form and sign a copy of this form. We will also scan copies of your driver's license and insurance card into your electronic chart.

MINORS

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed "Consent to Treat" release is required for minors brought in by anyone other than the parent or guardian. We will not bill a non-custodial parent on behalf of the custodial parent. If the minor is listed on appropriate insurance information, we will bill insurance. Dependents 18 years and older will be placed on their own account.

CO-PAYS

Patients are expected to present an insurance card or verify insurance at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. No post-dated checks will be accepted.

INSURANCE CLAIMS

Insurance is a contract between you and your insurance company. Our office will submit claims to insurance companies we are contracted with and will assist patients in any reasonable way with insurance claims. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill.
Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. Our office participates in many insurance plans. As a part of these plans, our fees are contracted and may change. Our participation in these programs is also subject to change. Patients must verify our participation with their plan at the time of their visit. Changes in participation with an insurance contract will be mailed to the patient within 30 days of contract termination. If insurance is not paid within 90 days, the bill becomes the responsibility of the patient. It is also the patient's responsibility to dispute any insurance claims with the insurance company. It is the patient's responsibility to know their insurance benefits. Patients will be billed for services not covered by insurance.

SPRINGFIELD
FAMILY PHYSICIANS

PATIENT RESPONSIBILITY FOR PAYMENT

If you are unable to pay and have a good credit history with our office, we may allow you to pay for services on an automatic payment plan. Timely monthly payments are expected. Missing a payment means that you have broken the contract with us and may result in a referral to a collection agency and/or dismissal from the practice. If you are on a payment plan or have had payment issues in the past, we will place your account on "Cash Pay" terms. This means we will require payment of a deposit before you see the provider.
We accept payment by cash, check, VISA, MasterCard, AMEX or Discover card. We do not hold checks or accept post-dated checks.

BILLING

You will receive a monthly statement listing all services, payments, and adjustments. The statement will specify an amount due from you, and payment is due upon receipt. If you have no insurance coverage and have difficulty paying for medical care due to limited income, please speak to a business office representative.

WORKERS' COMPENSATION

It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the workers' compensation insurance carrier denies the claim, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

NON-PAYMENT

If you do not pay the patient's due portion of your bill, our collection analyst will send you a letter stating you must pay by a specific date. You must contact us if you would like to discuss payment arrangements. Please be aware that failure to pay will result in a referral to a collection agency, which may affect your credit rating. If we refer your account to a collection agency, you will be charged for all expenses including a $50 collection fee, and any reasonable attorney fees. Referral to a collection agency may result in dismissal from our practice.

SERVICE FROM OUTSIDE PROVIDERS

You may have additional medical services ordered by your provider, such as laboratory, pathology, or other radiology tests. Our staff may draw your blood or other samples and send it to an outside provider. You will receive a separate bill from that provider for their services.

I have received and read Financial Policy for Springfield Family Physicians. I understand my responsibilities as a patient, including providing the practice with insurance information, understanding my insurance benefits, and payment of my account. If it becomes necessary to transfer my account to collections, I agree to pay all associated costs and fees. I have received a copy of this policy for my records.

Patient name (printed)_____ Date of birth_____

Signature _____Date _____

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Springfield Family Physicians – Centennial Clinic – McKenzie Valley Primary Care

RIGHT OF ACCESS FOR FAMILY/FRIEND (HIPAA)

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

I, _____, direct my health care and medical service providers to disclose and release my protected health information described below to:

Name: _____Relationship: _____

Contact information: _____

Name: _____Relationship: _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above – (Check appropriate box below)

☐ Disclose my complete health record (including but not limited to diagnoses, lab tests, treatment, and billing, for all conditions)

☐ Disclose my health record, **BUT DO NOT DISCLOSE THE FOLLOWING CHECKED ITEMS** (check as appropriate):

_____Mental health records

_____Communicable diseases (including HIV/AIDS)

_____Alcohol/drug abuse treatment

_____Genetic information

_____Other (please specify):

_____

Form of disclosure (unless another format is mutually agreed upon between my provider and designee) will be an electronic record via access through an online portal, hard copy, or verbally.

This authorization shall be in effect unless you request a change and will replace and previous form on file. You may revoke this authorization in writing at any time by notifying Springfield Family Physicians.

Name of Patient _____Date of Birth _____

Signature _____Todays Date _____

RECORDS RELEASE FORM – INCOMING

Phone 541-747-4300 Fax 541-747-0655
Springfield Family Physicians
Centennial Clinic
McKenzie Valley Primary Care

Patient Name (please print) _____

Date of Birth _____

Phone Number (where you can be reached):_____

Please send records by:____Fax____Mail_____I will pick up.

Please send to Springfield Family Physicians *2280 Marcola Road - Springfield, Oregon 97477*

- The past 2 years of clinical notes and lab reports
- The past 5 years of x-ray, diagnostic and operative reports
- Any of the initialed notes/reports listed below.

By initialing the spaces below, I specifically authorize the release of the following medical records if such records exist.

( ) Mental health records
( ) HIV/AIDS related records
( ) Drug/Alcohol diagnosis and/or treatment
( ) Genetic testing information

I authorize the release of my medical records from my previous medical provider:

Provider's name:_____Clinic Name _____

Clinic address: _____Phone #:_____

City: _____State/Zip: _____ Fax #: _____

I understand that the purpose of this release is for on-going medical care. The recipient of these records cannot transfer them to another party without consent from me or an authorized representative. This authorization will remain in effect for six months from the date of signature. To revoke authorization at any time, a written notice to revoke is required. I understand that medical records may contain information about alcoholism, drug abuse, sexually transmitted diseases, mental health concerns, or other sensitive information. I agree to the release of these records only as initialed above and have read all of this release. Any questions or concerns of mine have been answered.

_____ _____

Signature of patient or authorized representative Today's date

PLEASE RETURN A COPY OF THIS PATIENT AUTHORIZATION WITH RECORDS

Springfield Family Physicians
2280 Marcola Road*Springfield

Centennial Clinic
1800 Centennial*Springfield

McKenzie Valley Primary Care
2644 Suzanne Way*Eugene

SPRINGFIELD
FAMILY PHYSICIANS

541-747-4300
Springfield Family Physicians – Centennial Clinic – McKenzie Valley Primary Care

PATIENT PORTAL

Join us in making your healthcare efficient and accessible with our online Patient Portal. This program allows you to access your health records 24/7 from the convenience of your home. The Patient Portal is not direct email access to your provider. Internet access and a valid email address is required to access the Patient Portal.

PATIENT PORTAL SERVICES

- Review appointment verification of date and time.
- Update medical history forms online so they are readily available at your next visit.
- View lab and in-house x-ray reports
- View current and previous billing statements.
- Pay your bill.
- Update home and mailing address phone number, employer, and pharmacy.
- E-mail communication with your care team.
- Request refill of prescriptions, lab test and referrals

SERVICES NOT OFFERED

- Schedule same day medical appointments. Please call 541-747-4300 to schedule
- Forward portal email to an outside account (Gmail, Outlook, etc.). All communications are only accessible inside the portal
- Update insurance information. Please call the business office at 541-747-4300 and speak to our business office

The patient portal can be accessed through our website at https://www.nwmedicalhomes.com/patient-portal or on your mobile phone through the Healow app. **THE PORTAL IS NOT FOR URGENT REQUESTS**, please continue to call our office at 541-747-4300 for urgent needs. If you would like to participate in the patient portal, please provide your e-mail address below.

Patient name _____

Date of Birth _____

Patient e-mail address _____

SPRINGFIELD
FAMILY PHYSICIANS

Policy on Reasonable Expectations for Patient Care

Purpose: This policy aims to establish clear and realistic expectations for patients regarding the healthcare services they will receive, ensuring transparency, communication, and mutual understanding between healthcare providers and patients.

Scope: This policy applies to all patients receiving healthcare services within Northwest Medical Homes.

Policy Statement: At Springfield Family Physicians we are committed to providing high-quality healthcare services to our patients. To maintain clear communication and foster mutual understanding, it is essential for patients to have reasonable expectations regarding their care. To ensure this, the following guidelines are established:

Transparency

- We will provide clear and honest information regarding the services we offer, including their limitations and potential outcomes.
- Patients will be informed about the expected duration of treatment, possible side effects, and any necessary follow-up care.

Realistic Expectations

- Patients will be informed about the realistic outcomes of their treatment based on their individual condition, medical history, and other relevant factors.
- We will strive to meet the following expectations regarding response times from our office.

1. Appointment availability – We are open 8 AM to 8 PM Monday through Friday, and 9-5 on Saturdays. We reserve same day appointment availability for sick visits. Please expect to schedule chronic care visits 4 weeks in advance and well visits 1-3 months in advance.
2. **We do not have walk-in appointments**. Please preschedule all appointments.
3. Results of tests or imaging – Please give us 7-10 days to relay normal test results via our patient portal, Klara texting, or letter. We are aware that your test results may be published to the portal before our provider has had a chance to review them. Please know that some results are labeled as “abnormal” that may not be a problem. Trust that we will contact you if your lab values are clinically significant.
4. Filling out paperwork or ordering medical equipment – Paperwork requires an office visit. Medical equipment is hard to get insurance to pay for, if you are in a hurry, you may need to pay out of pocket and submit this to your insurance company later.

5. Referrals – Please expect a return call within 48 hours If you call about the status of a referral. If you are expecting a call from a specialty office, their response time can vary depending on urgency. Please feel free to reach out to the specialist directly if you have not heard from them within a week or two.
6. Text and portal messages – These are for non-urgent communication, please give us 24 hours to respond to these messages.
7. Phone calls – Telephone messages are triaged by urgency/medical severity, not necessarily the order in which calls come in. Urgent messages related to illness are prioritized over routine questions.
8. Prescriptions – Please allow 72 hours to process refill requests. We do not refill controlled substances on weekends/holidays or after 5 pm.

Managing Unreasonable Expectations:

- In cases where patients have unrealistic expectations, healthcare providers will work with them to provide education and clarification about their condition and treatment options.
- Patients will be encouraged to seek support from healthcare providers, family members, or other resources to address unrealistic expectations.

SPRINGFIELD
FAMILY PHYSICIANS

541-747-4300
Springfield Family Physicians-Centennial Clinic-Mckenzie Valley Primary Care

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record.
- Correct your paper or electronic medical record.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we have shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition.
- Providing disaster relief
- Include you in a hospital directory.
- Provide mental health care.
- Market our services

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Bill for your services
- Help with public health and safety issues.
- Do research.
- Respond to organ and tissue donation requests.
- Working with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

➤ ***See pages 3 and 4*** *for More information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We may provide this information through our patient portal.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

You can ask us to correct health information about you that you think is incorrect or incomplete.

We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communication.

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurance. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.

Choose someone to act for you.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

You can file a complaint if you feel we have violated your rights by contacting our Privacy officer at 541-747-4300 or writing to Springfield Family Physicans ATTN: Privacy Officer 2280 Marcola Rd. Springfield, OR 97477

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to	Share information with your family, close friends, or others involved in your care. Share information in a disaster relief situation. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission.	Marketing purposes Sales of your information Sharing of psychotherapy notes, alcohol and substance abuse, genetic information, HIV/AIDS, or reproductive health.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	We can use and share your health information to bill and receive payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues.	We can share health information about you for certain situations such as: Preventing disease -Helping with product recalls -Reporting adverse reactions to medications -Reporting suspected abuse, neglect, or domestic violence -Preventing or reducing a serious threat to anyone's health or safety.
Do research	We can use or share your information for health research such as related to the evaluation of certain treatments or prevention of a disease.
Law enforcement	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services.
Respond to organ and tissue donation requests.	We can share health information about you with organ procurement organizations.
Working with a medical examiner or funeral director.	We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation and other government requests.	We can use or share health information to the necessary extent about you: For workers' compensation claims. For special government functions such as military and national security.
Respond to lawsuits and legal actions.	We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and provide you with a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind and would no longer like to have your information shared at ATTENTION: Privacy Officer 2280 Marcola Rd. Springfield, OR 97477

April 2022

This Notice of Privacy Practices applies to all Northwest Medical Homes facilities.

Springfield Family Physicians: 2280 Marcola Road Springfield, OR 97477

Centennial Clinic: 1800 Centennial Blvd. Springfield, OR 97477

McKenzie Valley Primary Care * 2644 Suzanne Way * Eugene, OR 97408

WHAT SHOULD I DO IF I GET SICK OR HURT?

CALL US

- Burning/frequent urination
- Cough
- Sore throat
- Dizziness
- Muscle pain
- Joint pain
- Stomach pain
- Pelvic pain
- Headache
- Minor injury
- Ongoing health issues

GO TO URGENT CARE

- If you have a health concern that cannot wait for our office to reopen

Unsure? Give us a call!

541.747.4300

7:00am-8:00pm

GO TO EMERGENCY ROOM

- Life-threating condition
- Chest pain
- Slurred speech
- One-sided weakness

Use Klara to connect with your Healthcare team!

- **No login to remember**
- **No password to remember**
- **No app download**

Chat With Us Today!

Visit www.nwmedicalhomes.com!

NORTHWEST
MEDICAL HOMES

Klara

Questions?

Give us a call at 541-747-4300

What is Klara?

Klara is a secure, HIPAA compliant, platform that allows you to communicate directly with your healthcare team!

By using Klara, you get your message to the appropriate contact without having to call the office and wait on hold.

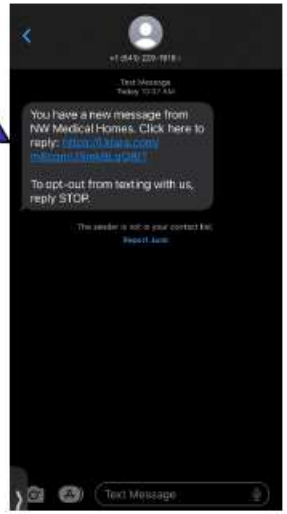
With Klara, all messages are in concise threads! This allows for streamline, prioritized care!

All conversations are encrypted, and private. Your personal health information is in good hands!

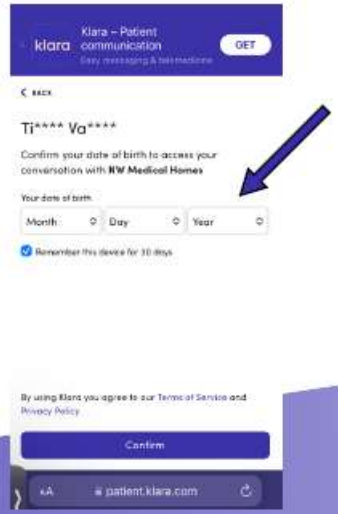
klara

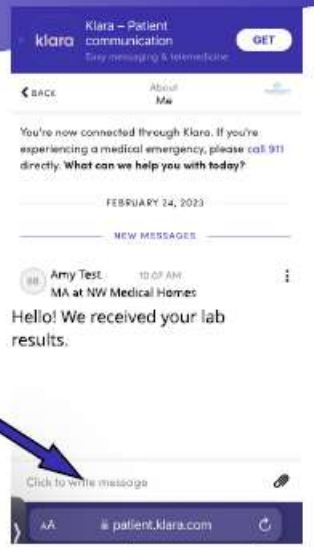
How it works:

When we reach out to you using Klara, you will receive a text message from 541-229-1918 with a link!



Click on the link in your text message to go to the Klara patient website! Enter your date of birth!





Review and respond to your message!

You can also chat with your healthcare team by visiting our website at nwmedicalhomes.com and clicking on the "message" button!