1040 N.W. 22nd Avenue • Suite 330 • Portland, OR 97210 • Phone 503 274-9936 • Fax 503 274-2660
www.CascadeWomensHealth.org

Please Print and Fill out Completely **NAME YOU PREFER TO BE CALLED:**_____

PATIENT INFORMATION				
PATIENT'S NAME: LAST FIRST MI			DATE OF BIRTH:	SOCIAL SECURITY NO.:
STREET ADDRESS, APT. NO.:		CITY AND STATE:		ZIP CODE:
HOME PHONE: OK TO LEAVE DETAILED VOICEMAIL? ☐Y ☐ N		WORK PHONE: OK TO LEAVE DETAILED VOICEMAIL? ☐Y ☐N		
MOBILE PHONE: OK TO LEAVE DETAILED VOICEMAIL? ☐Y ☐N		TEXT OPT-IN? ☐Y ☐ N (YOU WILL RECEIVE AUTOMATED APPOINTMENT REMINDERS)		
PREFERRED PHONE: ☐HOME ☐WORK ☐MOBILE		PATIENT'S EMAIL ADDRESS:		
LEGAL SEX: ☐FEMALE ☐MALE		SEX ASSIGNED AT BIRTH: ☐FEMALE ☐MALE ☐INTERSEX ☐UNCERTAIN ☐UNKNOWN		
GENDER IDENTITY: ☐FEMALE ☐MALE ☐NON-BINARY/GENDERQUEER ☐TRANSGENDER FEMALE ☐TRANSGENDER MALE ☐ OTHER_____				
PREFERRED PRONOUNS: ☐SHE/HER/HERS ☐HE/HIM/HIS ☐THEY/THEM/THEIRS ☐OTHER:_____				
ETHNICITY: ☐ NON-HISPANIC ☐ HISPANIC/LATINO ☐UNKNOWN ☐DECLINE		RACE:☐AMERICAN INDIAN ☐ASIAN ☐BLACK/AFRICAN AMERICAN ☐HISPANIC/LATINO ☐NATIVE HAWAIIAN/PACIFIC ISLANDER ☐WHITE/CAUCASIAN ☐UNKNOWN ☐DECLINE ☐OTHER:_____		
PREFERRED LANGUAGE:	COUNTRY OF ORIGIN:	RELIGION:	MARITAL STATUS: ☐DIVORCED ☐DOMESTIC PARTNER ☐MARRIED ☐SEPARATED ☐SIGNIFICANT OTHER ☐SINGLE ☐WIDOW ☐OTHER	
PATIENT'S EMPLOYER:		EMPLOYMENT STATUS: ☐FULL ☐PART ☐SELF EMPLOYED ☐NOT EMPLOYED ☐RETIRED ☐ACTIVE MILITARY		STUDENT: ☐FULL ☐PART
PRIMARY CARE PHYSICIAN:		ADDRESS:		
PHONE NUMBER:		HOW DID YOU HEAR ABOUT US? ☐FRIEND/FAMILY ☐DOCTOR ☐INSURANCE ☐YELP ☐INTERNET SEARCH/GOOGLE		

EMERGENCY CONTACT		
NAME:	RELATIONSHIP:	PHONE NUMBER:
NAME:	RELATIONSHIP:	PHONE NUMBER:

(OVER→)

COMPLETE ONLY IF THE PATIENT IS A MINOR			
MOTHER/GUARDIAN'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY NO.:	
STREET ADDRESS, APT NO: ☐SAME AS PATIENT	CITY AND STATE:	ZIP CODE:	
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
FATHER/GUARDIAN'S NAME:	DATE OF BIRTH:	SOCIAL SECURITY NO.:	
STREET ADDRESS, APT NO.: ☐SAME AS PATIENT	CITY AND STATE:	ZIP CODE.:	
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME:	GROUP NUMBER:	SUBSCRIBER/MEMBER ID:	
POLICY HOLDER'S NAME: ☐SAME AS PATIENT	DATE OF BIRTH:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:	
STREET ADDRESS, APT NO.: ☐SAME AS PATIENT	CITY AND STATE:	ZIP CODE:	
SUBSCRIBER'S EMPLOYER:	PHONE NUMBER: ☐CELL ☐WORK ☐HOME	SOCIAL SECURITY NUMBER:	
SECONDARY/SUPPLEMENTAL INSURANCE NAME *:	GROUP NUMBER:	SUBSCRIBER/MEMBER ID:	
POLICY HOLDER'S NAME: ☐SAME AS PATIENT	DATE OF BIRTH:	PATIENT'S RELATIONSHIP TO SUBSCRIBER:	
STREET ADDRESS, APT NO.: ☐SAME AS PATIENT	CITY AND STATE:	ZIP CODE:	
SUBSCRIBER'S EMPLOYER:	PHONE NUMBER: ☐CELL ☐WORK ☐HOME	SOCIAL SECURITY NUMBER:	

* WE MAY BE ABLE TO BILL YOUR SECONDARY/SUPPLEMENTAL INSURANCE (PLEASE CHECK WITH RECEPTION DESK FOR CLARIFICATION).

X_____ _____ _____ _____

SIGNATURE OF PATIENT, PARENT OR LEGALLY RESPONSIBLE PERSON | PRINT NAME | RELATIONSHIP | DATE

(OVER→)

CREDIT POLICY/ASSIGNMENT OF BENEFITS

Patient responsibilty:

Patients are responsible for all charges resulting from services provided by Cascade Women's Health, P.C. If insured, it is you, the patient's responsibility to know your insurance coverage and check with your insurance in advance of your appointment to be sure that CWH is in-plan with your network. We encourage every patient to know and understand your policy. Please be aware that some of the treatment plans and office visits may not be covered by your insurance. If you have any questions regarding coverage, please call your insurance company directly **before** your visit.

As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment will be due within 30 days of the first billing, unless financial arrangements have been made. A late fee of **$10.00** after 60 days will be applied to any overdue balance. A **$50.00** charge will be added to any unpaid balance that is sent from our billing department to an outside collection agency. Please note, we are willing to work with you to create a plan of regular monthly payments if necessary.

Copays are due at time of service. We collect from patients whose cards clearly state amount to be collected. We accept cash, check, Visa, MasterCard and Discover. We are a specialist office and will collect specialist copays for all visits other than routine.

Minors: The undersigned agrees to be responsible for any and all balances for services rendered to the minor patient.

In-office procedures: We will call your insurance carrier to check benefits on procedures prior to your appointment. We require a deposit of **$150.00** for these services **at time of service** unless other payment arrangements have been made. If your insurance covers these services at 100%, no deposit will be required. If the amount due, according to your insurance benefit, is less than $150, we will collect stated amount. If there is a balance due beyond $150, you will be billed. If necessary, payment arrangements can be made prior to your appointment by calling our billing department at 503-274-9936 x16 or 19.

> ***Please note:** We do our best at time of service to calculate the exact amount owed for services rendered according to established medical codes and information provided by you and your insurance company. On rare occasion, mistakes are made that once corrected may result in further billing or in the case of overpayment by a patient, a refund due. We review patient accounts monthly and in the case of overpayment, send patient refunds out on the last day of each month.

Self Pay Patients:

New patients without insurance: A minimum deposit of **$150.00** will be collected at time of visit. The patient or responsible party will then be billed for any balance owing from that visit. All private pay patients will receive a 20% discount on total charges. If the patient is able to pay in-full at time of service, the patient will receive a 5% Prompt Pay discount.

Established patients without insurance: A minimum deposit of **$75.00** will be collected at time of visit. The patient or responsible party will then be billed for any balance owing from that visit. All private pay patients will receive a 20% discount on total charges. If the patient is able to pay in-full at time of service, the patient will receive a 5% Prompt Pay discount.

Insurance Billings:

Providing correct insurance information is your responsibility. As a courtesy to you, we will bill your primary insurance company. You will need to bring your current insurance card with you to every appointment.

Referrals:

If you are required by your insurance company to obtain a referral or prior authorization, it is your responsibility to get one prior to your appointment.

Outside Scheduling:

As a service to you, we schedule appointments outside of our office for labs, ultrasounds and surgeries. It is the patient's responsibility to know which facility is in-plan with your benefits and to let the front desk know. An out-of-plan facility can lead to reduction in your benefits and an increase in cost for you. All outside services are billed directly by those services, not CWH. Questions related to bills for outside services should be made directly to those entities (labs, ultrasounds and hospitals).

Returned check fee:

It is our clinic's policy to charge all patients a **$35.00** fee for checks that are returned unpaid by the bank.

I herby authorize Cascade Women's Health, P.C. to release any medical information necessary to process claims with any insurance companies. I also assign Cascade Women's Health, P.C. all payments I am entitled for medical and surgical expenses related to the services reported herewith. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more then 90 days will be subject to a processing fee.

I have read and received a copy of the credit policy for Cascade Women's Health, P.C. I accept this policy for services rendered by Cascade Women's Health P.C.

_____ _____

Print your name **Date**

_____

Patient Signature
(or guardian if the patient is a minor)

HIPAA ACKNOWLEDGMENT AND CONSENT

I understand that **CASCADE WOMEN'S HEALTH, P.C.** (referred to below as "This 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, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This 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, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, Claims and related information to insurance companies or others who may be responsible to pay some or all of health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will Handle health information about me. This written description is known as a Notice of Privacy Practices anddescribes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This 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 a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/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 them manner described in the Notice of Privacy Practices, and understand that Cascade Women's Health, P.C. is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient Representative)

Description of Representative'sAuthority: _____

Patient Name:_____

Your Email:_____

Provider: (please circle) Dr. Kung Dr. Suzuki Dr. Collins
Dr. Riley Dr. Cohen Dr. Lind

RISK OF USING EMAIL

Transmitting patient information by email has a few risks that patients should consider before using email. These include, but are not limited to, the following risks:

a) Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) Email senders can readily misaddress an email.
c) Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect email transmitted through their systems.
e) Email can be intercepted, altered, forwarded, or used without authorization or detection.
f) Email can be used to introduce viruses into computer systems.
g) Email can be used as evidence in court.
h) Emails may not be secure and therefore it is possible that the confidentiality of such communications may be breeched by a third party.

CONDITIONS FOR THE USE OF EMAILS

Providers cannot guarantee, but will use, reasonable means to maintain security and confidentiality of email information sent and received. Providers are not liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Patients must acknowledge and consent to the following conditions:
a) Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that a specific email will be read and responded to within any specific time.
b) Email must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
c) All email will usually be printed and scanned into the patient medical record.
d) Office staff may receive and read your messages.
e) Provider will not forward patient identifiable emails without the patient's prior written consent, except as authorized or required by law.
f) The patient should not use email for communications regarding sensitive medical information.
g) Provider is not liable for breach of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS

To communicate by email the patient shall:

a) Avoid the use of his/her employer's computer.
b) Put the patient's name in the body of the email.
c) Key in the topic (e.g. medical questions, billing question) in the subject line.
d) Inform provider of changes in his/her email address.
e) Acknowledge any email received from the Provider.
f) Take precautions to preserve the confidentiality of the email.
g) Withdraw consent only by email or written communication to Provider.

Telehealth Consent

Cascade Women's Health PC may ask if you wish to conduct some of your visits through Telehealth consults. A Telehealth visit is a HIPAA-compliant electronic method (via phone or video conferencing), by which your provider will consult with you about your concerns and if appropriate, develop a treatment plan. Telehealth visits will help to minimize need to come to the office. Not all concerns can be addressed in this manner, however.

There are potential risks with the use of this technology that include, but are not limited to:

- interrupted visits due to poor phone or internet connection
- you might be required to make a clinic appointment if the information gathered through the telehealth visit is not sufficient to make an appropriate diagnosis.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and or telehealth between the Providers and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Provider may impose to communicate with me by email or telehealth. If I have any questions, I may inquire with my treating physician.

Patient signature _____

Date _____

Cascade Women's Health, PC

Patient Health History

Full Name:_____ Date of Birth:_____

What pharmacy do you use?_____

Address _____Phone# _____

Do you prefer to have a provider assistant present at the time of your examination? ☐Y ☐N

Reason for your visit today:_____

Current Medications (please list below or attach list):
Supplements:
Allergies to medications/latex/adhesives? ☐Y ☐N (If yes, please list below):
Do you have any dietary restrictions/special diet? ☐Y ☐N (if yes, please list below):
Prior Surgeries? ☐Y ☐N (if yes, please list below):

First day of your last menstrual period?_____ How frequent are your periods?_____

Number of pregnancies:_____ Birth: ☐Y ☐N Miscarriage: ☐Y ☐N Abortion: ☐Y ☐N

Current method of birth control?_____ Are you satisfied with this method? ☐Y ☐N

Date of last pap?_____ Any history of abnormal pap? ☐Y ☐N Date:_____ Result:_____

Date of most recent mammogram?_____ Age when you began having menstrual periods?_____

Have you completed the Gardasil (HPV) vaccination series? ☐Y ☐N

Sexual Orientation: ☐Straight/Heterosexual ☐Gay ☐Lesbian ☐Bisexual ☐Pansexual ☐Queer ☐Asexual

☐Don't Know ☐Questioning ☐Choose not to disclose ☐Something else _____

Sexually active? ☐Yes ☐Not currently ☐Never

Age when you began having sexual relations?_____ Do you have sex with men, women or both?_____

How many partners have you had sex with in your lifetime? ☐0 ☐1 ☐2-4 ☐5-20 ☐20+

Any new sex partners in the last year? ☐Y ☐N Any history of Sexually Transmitted Diseases or Infections? ☐Y ☐N

Would you like to be screened for Sexually Transmitted Infections (please note: some insurance plans do not cover if only for screening)? ☐Y ☐N

(OVER→)

Full Name:_____ Date of Birth:_____

Do you feel verbally or physically intimidated by your partner or anyone in your household? ☐Y ☐N

Any history of verbal/physical/sexual abuse? ☐Y ☐N

I am: ☐Single ☐Engaged ☐Married ☐Living with partner ☐Divorced ☐Widowed ☐Dating

Past medical history: Have you ever had any of the following?

Abnormal uterine bleeding	N	Y
Abuse	N	Y
Anemia	N	Y
Anesthesia complications	N	Y
Anxiety Disorder	N	Y
Asthma	N	Y
Bladder issue	N	Y
Blood transfusion	N	Y
Breast disease - benign	N	Y
Cancer	N	Y
Deep Vein Thrombosis	N	Y
Depression	N	Y
Excessive alcohol use	N	Y
Endometriosis	N	Y
Eye issue	N	Y
Fibroid uterus	N	Y
GI issue	N	Y
Gestational diabetes	N	Y
Headaches/migraines	N	Y
Heart disease	N	Y

Hepatitis	N	Y
Herpes	N	Y
Elevated blood pressure	N	Y
Infertility	N	Y
Injury/trauma	N	Y
Kidney disease	N	Y
Elevated cholesterol	N	Y
Liver problem	N	Y
Lung disease	N	Y
Neurological issue	N	Y
Pulmonary Embolism	N	Y
Pain	N	Y
Pregnancy complication	N	Y
Skin disorder	N	Y
Sleep disorder	N	Y
Thyroid problems	N	Y
UTI	N	Y
Varicosities	N	Y
Vitamin deficiency	N	Y
Other	N	Y

Please circle all appropriate answers	Parents		Siblings		Maternal		Paternal		Aunt/Uncle	
Heart attack	M	F	Br	Sis	GM	GF	GM	GF	A	U
Stroke	M	F	Br	Sis	GM	GF	GM	GF	A	U
Blood clots	M	F	Br	Sis	GM	GF	GM	GF	A	U
DVT	M	F	Br	Sis	GM	GF	GM	GF	A	U
High BP	M	F	Br	Sis	GM	GF	GM	GF	A	U
Diabetes	M	F	Br	Sis	GM	GF	GM	GF	A	U
Breast Cancer	M	F	Br	Sis	GM	GF	GM	GF	A	U
Ovarian Cancer	M	F	Br	Sis	GM	GF	GM	GF	A	U
Other Cancer	M	F	Br	Sis	GM	GF	GM	GF	A	U
Too much bleeding	M	F	Br	Sis	GM	GF	GM	GF	A	U

Do you vape? ☐Y ☐N Do you smoke? ☐Y ☐N If yes, how many cigarettes a day?_____
Have you smoked in the past? ☐Y ☐N If yes, how much?_____ Date quit?_____

How many drinks of alcohol do you drink per week? ☐0 ☐Rare ☐1-7 ☐14+

Do you use any other substances? ☐Y ☐N ☐Currently ☐Never Type:_____

(OVER→)

Cascade Women's Health, PC

Review of Systems for New Patients

Full Name:_____ Date of Birth:_____

Please circle any of the following that you have experienced in the past year:

Menstrual: Irregular menses / Bleeding between menses / Painful menses / Pain with sex / Vaginal d/c

General: Chills or fever / Unusual fatigue / Sexual dysfunction / Excessive thirst / Change in sleep / Swollen glands / Weight change / Cold or heat intolerance

Eyes/Ears: Change in vision / Blurry vision / Double vision / Eye pain / Hearing loss / Ringing in ears / Infection or drainage / Earache

Throat/Nose: Hoarseness / Frequent sore throat / Bleeding gums / Difficulty swallowing / Nose bleeds / Nasal stuffiness / Runny nose

Breasts: Lump / Pain / Discharge

Skin: Rash / Bruise easily / Change in mole / Change in hair growth

Heart/Lungs: Racing or fluttering / Chest pain or discomfort / Swollen feet or ankles / Persistent cough / Coughing up blood / Trouble breathing / Wheezing / Shortness of breath

GI: Heartburn / Gas / Nausea or vomiting / Constipation / Loose stools / Bloody or black stools / Hemorrhoids / Abdominal pain

Urinary: Pain / Burning with urination / Frequency / Loss of urine with cough or sneeze / Blood in urine

Bones/Joints: Painful or stiff joints / Joint swelling / Back or neck pain

Neurologic: Muscle weakness / Numbness or tingling / Tremor / Seizures / Frequent headaches / Dizziness / Loss of balance / Fainting / Loss of sensation

Mood/Stress: Memory change / Frequent crying / Depression / Tension or stress / Considered suicide / Job problems / Job change / Death of family member / Illness of family member / Family conflict / Financial problems / Addiction / Eating disorder / Divorce

Over the past 2 weeks, how often have you been bothered by any of the following problems? (please circle)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed or hopeless?	0	1	2	3