Bear Valley
MEDICAL CLINIC, LLC

Our mission at Bear Valley Medical Clinic, LLC is to promote and establish health and well-being to individuals in our community in a safe, friendly, and compassionate environment. Our team works to master professional skills to develop and maintain primary care for our patients.

At Bear Valley Medical Clinic, LLC we provide initial medical care and provide referring and coordinating medical services. We envision a system of care with quality treatment and support that is responsive to an individual's preferences and values using evidence-based care. We will continue to expand our education to learn new and successful treatment strategies to share with our patients.

At Bear Valley Medical Clinic, we value communication between patients and our clinical team. We will serve the needs of all patients while striving to understand rather than judge an individual. Honesty, diversity, and equality are standards we hold for our patients as well as our clinical team.

Please take the time to complete your New Patient Packet in full, as an incomplete packet will delay our intake process.

- Print as clearly as possible to avoid transcription errors.
- Once you are finished with your packet, please return it to our office for processing.
- Be sure to bring your **ID, insurance cards, and medications to every visit**.
- Allow up to 7 business days for our office to process your paperwork and call you to schedule an appointment.
- Please make sure to do pre-registration forms prior to **EACH** appointment.

Tuesday – Thursday*: 8 a.m. to 5 p.m.

Friday*: 8 a.m. to 4 p.m.

Saturday, Sunday, and Monday: Closed

***Office closed for lunch:** 12 p.m. to 1 p.m.

1690 NE Lynda Lane, Grants Pass, OR 97526
Phone: (541) 237-5040 | Fax: (541) 237-5041
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NEW PATIENT PAPERWORK

Patient information:

Full Name: _____ Preferred Name:_____

Address: _____

City: _____ State: _____ Zip Code:_____

DOB:_____Age: _____ Gender: _____ Social Security Number: _____

Ethnicity: ☐ Decline ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Race: ☐ Decline ☐ White/Caucasian ☐ American Indian/Alaska Native
☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other

Contact information:

Primary Phone:_____ Secondary Phone:_____

Do you have a working voicemail? ☐ Yes ☐ No

May we leave a detailed voicemail? ☐ Yes ☐ No

May we text and email your billing statements? ☐ Yes ☐ No

Email Address: _____

An email address allows you to access our **Elation Patient Passport. This lets you see appointments, complete pre-registration forms, receive important messages, and view lab results. Please see our Elation's Patient Portal form for details on how to sign-up.*

Telehealth:

On occasion, we can offer, or you can request a telehealth appointment with your Provider in the privacy of your home rather than an in-office visit. Through our Electronic Health Record (EHR)system, we can provide a telehealth appointment through a real time, two way communication with audio and video capabilities through Zoom Meetings. This is a safe and secure link used through our EHR, but is not a recorded encounter. Prior to these appointments, you would receive a text and/or email that contains instructions and the link to connect. Telehealth is not a requirement, and is a case by case basis and your insurance may not cover now that the pandemic is over.. It does require a private internet connection. Your Provider may decide you still need an in office visit, but this can provide a great alternative if necessary. As we schedule you an appointment and we agree a telehealth option is necessary or requested, please sign below as consent to proceed with this appointment type.

Signature:_____ Date:_____

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NEW PATIENT PAPERWORK *(continued)*

Emergency Contact:

If we can disclose health information and appointment to this person, please initial here: _____

Name: _____

Phone Number: _____ Relationship to Patient: _____

Is the patient under the age of 18? ☐ Yes ☐ No

If yes, please list parent/guardian information below:

Full Name: _____

Relationship to patient: _____ Phone Number _____

Address: _____

City: _____ State: _____ Zip Code: _____

Is this child in Foster Care? ☐ Yes ☐ No

If yes, who is the patient's guardian? _____

Please provide the name and phone number of the assigned case worker:

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

If employed, what is your occupation and employer?

_____

Preferred Pharmacy: _____ Cross Street: _____

City: _____ State: _____

Some local Pharmacies are:

Please be sure to contact you pharmacy first with refill request and to check if your medication is ready to pick up. If your medication isn't available at your pharmacy, it is the patient's responsibility to find an alternate pharmacy, and we are happy to send it to the alternate.

- Grants Pass Pharmacy
- Fred Meyer Pharmacy
- Genoa Pharmacy
- Trinity Valley Pharmacy

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NEW PATIENT PAPERWORK *(continued)*

Insurance Information:

Do you have health insurance? ☐ Yes ☐ No ☐ Medicare ☐ Medicaid/OHP ☐ Other

Primary Insurance _____

Subscriber/Member ID# _____

Group # _____

Co-Pay Amount: _____

Claims Address: _____

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

Are you the subscriber/policyholder? ☐ *Yes* ☐ *No*

If no, who is the subscriber/policyholder?

Name: _____ *DOB:* _____

Relationship to patient: _____

Secondary Insurance _____

Subscriber/Member ID# _____

Group # _____

Co-Pay Amount: _____

Claims Address: _____

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

Are you the subscriber/policyholder? ☐ *Yes* ☐ *No*

If no, who is the subscriber/policyholder?

Name: _____ *DOB:* _____

Relationship to patient: _____

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HEALTH HISTORY INFORMATION

Please complete the following forms regarding your present and past medical history in full.

Medications/Prescriptions:

Please list all of your current medications, including over the counter, supplements, and vitamins.
Check here for **No Medications/Prescriptions** ☐

Medication Name	Dosage	How often?

Allergies:

Please check all that apply and list reaction to each allergy selected.

Medication	Reaction	Medical Supplies	Reaction	Food	Reaction
☐ **No drug allergies**	N/A	☐ **No other medical allergies**	N/A	☐ **No food allergies**	N/A
☐ Acetaminophen		☐ Adhesive Tape		☐ Corn	
☐ Antibiotic		☐ Iodine		☐ Dairy	
☐ Aspirin		☐ Latex		☐ Egg	
☐ Epinephrine		☐ Mercury		☐ Gluten	
☐ Ibuprofen		☐ Sulfa		☐ Nuts	
☐ NSAIDS		☐ Other		☐ Shellfish	
☐ Opioids				☐ Wheat	
☐ Penicillin				☐ Other food allergies	
☐ Statins					
☐ Tylenol					
☐ Other drug					

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HEALTH HISTORY INFORMATION *(continued)*

Please complete the following forms regarding your present and past medical history in full.

Past and Current Medical History

Check all that apply. Check here for **None** ☐

Diagnosis	Diagnosis	Diagnosis
☐ AIDS	☐ Diverticulitis	☐ Osteoporosis
☐ Anemia	☐ Dizziness	☐ Peptic Ulcer
☐ Anxiety Disorder	☐ Eczema	☐ Psoriasis
☐ Arthritis	☐ Esophageal Reflux	☐ PTSD
☐ Asthma	☐ Fibromyalgia	☐ Sleep Apnea
☐ Back Pain	☐ Gallstones	☐ Stroke
☐ Bipolar Disorder	☐ Hepatitis	☐ Thyroid Disorder
☐ Cardiac Arrest	☐ High Cholesterol	☐ Vomiting
☐ Chest Pain	☐ High Blood Pressure	☐
☐ COPD	☐ Insomnia	☐
☐ Chronic Pain Syndrome	☐ Kidney Disease	☐
☐ Deep Vein Thrombosis	☐ Liver Disease	☐
☐ Depression	☐ Migraines	☐
☐ Diabetes Type I	☐ Heart Attack (Myocardial Infarction)	☐
☐ Diabetes Type II	☐ Nausea	☐

Surgical History/Hospitalizations — Admissions only. Check here for **None** ☐

Year/When?	Procedure/Why?	Hospital/Where?

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FAMILY HEALTH HISTORY INFORMATION

Family Health History:

Please list your pertinent family history below. Be sure to specify how they are related to you, i.e.: mother, father, aunt, uncle etc. Check here for **None/Unknown** ☐

Condition	Who?

Last Preventative Procedures/Exams:

	Approximate Month & Year		Approximate Month & Year
Blood Draw/ Lab-work		Mammogram	
Colonoscopy		Physical Exam or Well Child Check	

Do you have a POLST, Advanced Directive, or Medical Power of Attorney? ☐ Yes ☐ No

**If yes, please provide us with a copy of that document.*

If you are over the age of 65, **or have a terminal condition**, would you like more information? ☐ Yes ☐ No

Social History:

Tobacco Smoking Status? *(excluding vaping or marijuana)*

☐ Current, every day ☐ Current, some days ☐ Never ☐ Former

What date did you start? _____ What date did you quit?_____

How many cigarettes do you smoke per day on average? _____

Would you like information and support on how to quit smoking? ☐ Yes ☐ No

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ePrescribing is defined as a provider's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have been included in an ePrescribe program. These include.

- **Formulary and benefit transactions** – gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – provides the provider with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Bear Valley Medical Clinic can request and use your prescriptions medication history from other healthcare provider and/or third party pharmacy benefit payers for treatment purposes.

Signature:_____ Date:_____
(Patient/Patient Representative/Guardian)

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ACKNOWLEDGMENT AND CONSENT

I understand that **Bear Valley Medical Clinic, LLC**. (referred to below as "BVMC"), may use and disclose health information about me.

I understand that my health information may include information both created and received by BVMC, may be in the form of written or electronic records or spoken words. This 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 BVMC may use and disclose 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;
- Submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care;
- Perform various office, administrative, and business functions that support my provider's efforts to be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how BVMC will handle health information about me. This written description is called Notice of Privacy Practices. This describes what health information is disclosed and how that information is used by employees, staff, and other office personnel of BVMC, 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 of the most current version of BVMC's Notice of Privacy Practices in effect will be posted in waiting/reception area and our website. Our Communication of Rights, Roles, & Responsibilities brochure will also be posted in the 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 the manner described in the Notice of Privacy Practices, and I understand that BVMC 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.

Signature:_____Date: _____

(Patient/Patient Representative/Guardian)

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FINANCIAL POLICY

Insurance co-payments, deductibles, and co-insurance: Insurance companies do not always pay fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. Deductibles, co-insurance, or non-covered services are to be paid in a timely fashion according to office policies. Copays are due at the time of your appointment and we are obligated to collect per our contract with your insurance. You accept responsibility for all such expenses, even if your insurance company is billed as a courtesy.

Financial Policy: You accept financial responsibility for all charges rendered to you. If you are the parent or guardian accompanying this patient, you assume this liability.

Private Pay: If our patients without insurance are not able to pay your account in full at time-of-service, you will need to make payment arrangements with our billing office. After these arrangements are made and payment is still not received, the account will be turned over to our collection agency.

Unusual and Customary Rates: Our practice is committed to providing the best treatment for our patients and what we charge is usual and customary for our area.

Parent/Child: The adult accompanying a child is responsible for payment at time-of-service including co-payment.

Checks: A fee of $25 will be assessed to your account for any checks returned for non-sufficient funds. We accept personal checks, credit cards, and cash.

☐ I authorize Bear Valley Medical Clinic, LLC to directly bill my insurance company. I authorize my insurance company to make payments directly to Bear Valley Medical Clinic, LLC. I understand that I am responsible for any parts of the charges not paid by my insurance including co-pay, co-insurance, and deductible.

By signing below, I attest that I have read, understand, and agree to Bear Valley Medical Clinic Financial Policies.

Signature:_____Date: _____

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ELATION'S PATIENT PASSPORT

Elation Health is the Electronic Health Record (EHR) System that Bear Valley Medical Clinic uses.

- Securely receive messages and attachments from your provider
- Appointment reminders
- Pre-registration forms

To be able to sign up, you will need to have email, and be able to receive text messages to your cell phone.

How to sign up:

1. **Look for an email from Elation Passport Support** in your email inbox (including junk mail). It will be sent to the email address that your provider's office has on file for you. Click "Sign into Passport" within the email to be directed to the registration web page.
2. **An invitation code will be sent to your mobile phone** via an SMS text message or, will be available on the printed registration page.
3. On the Registration Page **create a password and enter your Passport Invitation code** in the field labeled "Invitation Code" Press "Submit" and you're done.

Indicate whether the account you are registering for is for you (the patient) or for an individual that you are the caregiver/legal representative of. If you have multiple Passport accounts because you see or are the caregiver for multiple individuals **you may access those accounts through a single login.** You may also sign up with the same email address, and link the accounts after.

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CODE OF CONDUCT AND POLICY

Below you will find our policy regarding expected patient code of conduct. **Please review our policy carefully**. Once you have reviewed our policy, please sign acknowledging you have read and agree to the terms. We value all of our patients and strive to provide quality medical care to our community. To do so, we need to set boundaries and expectations that will foster an effective patient-provider relationship.

Please understand we serve the community, not just the individual. To provide a safe and healthy environment for staff, visitors, patients and their families, Bear Valley Medical Clinic (BVMC) expects visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

- Please **communicate your top 2 issues that you wish to discuss with the Provider when scheduling**, If you do not do this in advance, another visit may be necessary so that the Provider can give all patients the time and quality of care they deserve.
- Our practice follows a **zero-tolerance policy for rude/aggressive behavior** directed by patients (friends, family, or visitors included) against our staff and will result in immediate dismissal from our practice.
- Please be **courteous with the use of your cell phone** during office visits.
- Please refrain from excessive phone calls to our clinic. Although we are here to serve your health care needs, we also serve many others in the community. Please understand, each phone call must be documented and recorded. **Excessive phone calls to our clinic are disruptive** and hinders our ability to care for others.
- **We are NOT an Urgent Care, Emergency Department, or walk-in clinic**. Please do not expect to be seen the same day. Understand we keep slots in our schedule open for individuals needing to be seen the same day. These openings fill up fast and are not guaranteed.
- Please do NOT call BVMC requesting over-the-counter medications. **If you are wanting/ needing OTC medications please go to your local pharmacy**. If you are not sure what you need, ask to speak with your pharmacist. Pharmacists may be able to direct you to many OTC medications and can run these medications through insurance so the patient has less out of pocket expense. If you call requesting our office send an order for OTC medications to a pharmacy we will require an in office visit for this request.
- If you contract a mild cold and are experiencing symptoms, **please try self-care and over the counter treatments first** before calling our clinic requesting treatments.

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CODE OF CONDUCT AND POLICY *(continued)*

- Please come to your scheduled appointment on time with any required paperwork filled out prior to your appointment. **Pre-registration forms will be sent to you via email or text** prior to your appointment. If you do not show up to your appointment on time and have not completed prior paperwork your appointment may be rescheduled. We respect that your time is valuable, as well as ours.
- Patients are responsible for making requests to have medications refilled. **Please notify your pharmacy 72 hours in advance**. If a prescription request needs to be made to the office, **please allow 72 business hours to process**.
- **BVMC DOES NOT TREAT CHRONIC PAIN**. If you require chronic pain management, we will refer you to a Pain Management Clinic. We **DO NOT TREAT ANXIETY** or sleep disorders with short acting benzodiazepines (Xanax, Valium, etc.). These medications are monitored closely, and there are other options for treatment of these conditions that do not require the use of narcotics and benzodiazepines. Use of these medications are not congruent with current FDA guidelines and carry significant side effects.
- If you have any questions about the care or are unhappy with the service received in our office, **please contact our Clinic Manager (Cherie)**, so that any issues about your care and the services you received can be addressed.

By signing below, I attest that I have read, understand, and agree to Bear Valley Medical Clinic Code of Conduct and Policy.

Signature:_____Date: _____

Patient Printed Name: _____

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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____ hereby authorize:
Patient Name DOB

_____
Name of health care provider

_____
Fax Number

To disclose to:

Bear Valley Medical Clinic
1690 NE Lynda Lane
Grants Pass, OR 97526

Records and information for the past two (2) years pertaining to:

_____
Patient name (list other names used)

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

- ☐ Medical Information _____ (Initials)
- ☐ Psychiatric Information _____ (Initials)
- ☐ Drug/Alcohol Information _____ (Initials)
- ☐ Results of an HIV Test _____ (Initials)
- ☐ Genetic Records _____ (Initials)
- ☐ Other Health Information _____ (Initials and specify below)
- ☐ Specify the records to be disclosed: _____

The recipient may use the health information authorized on this form for the purpose of transferring care.

_____
Signature Date If signed by other than patient, indicate relationship