



FANNO CREEK
C L I N I C

Dear _____:

Welcome to Fanno Creek Clinic and thank you for choosing us for your healthcare needs. Your appointment with _____ is on _____ at _____. Please arrive 15-20 minutes early for the first appointment to complete the check-in process.

Enclosed you will find information for your review. Be sure to bring the completed health forms to your initial appointment along with your insurance card. For security and confidentiality reasons, we will ask for photo identification.

If your insurance company requires you to name a primary care provider, please make sure you have notified them of your new provider. If insurance coverage cannot be verified prior to your appointment, a \$100 deposit will be required at the time you check in for that visit. If you have concerns regarding this matter please feel free to contact our Clinic Administrator, Robert Gessele, ext 163.

Please note that Fanno Creek Clinic maintains a cancellation and reschedule policy that requires 24 hours notice. Unfortunately, if you fail to provide the required notice more than once, future appointments may not be scheduled. Once established as a patient, failure to provide 24 hours notice 3 times may result in dismissal from the clinic.

For your convenience, directions to our clinic are included in this packet. If you have any questions, please contact our office at (503) 452-0915 or visit us online at www.fannocreek.com. We look forward to seeing you in clinic.

Sincerely,

Fanno Creek Clinic Staff

Fanno Creek Clinic
2400 SW Vermont St.
Portland, Oregon 97219
(503) 452-0915
Fax: (503) 768-9232

Fanno Creek Clinic: General Information

Clinic Hours: The Clinic is open from 8:00 am until 5:00 pm Monday through Friday.

Emergencies: Dial 911 for life threatening emergencies. During business hours call the Clinic and your Doctor or a Nurse will assist you. After hours (5:00 pm – 8:00 am and weekends) you may reach the Doctor on call by calling the Clinic and entering extension 6. Leave a message and the Doctor will be paged immediately.

Prescription Refills: Please allow 72 hours (3-5 days) for your prescriptions to be refilled. No narcotics will be refilled after 5:00. Approximately one week before you will be running out, have your pharmacy fax us a request to refill it. Your pharmacist will be able to answer many questions you may have regarding your medication. The fax number is (503) 892-9875.

Same Day Appointments: All requests for appointments the same day you call will be triaged through a Nurse. Although the receptionists cannot make these appointments without authorization from the Doctor or a Nurse, they can make you an appointment for the next available opening.

Lab Hours: The Clinic lab is open from 8:00 am until 5:00 pm on Monday, Tuesday, Wednesday and Friday. It is open from 7:30 am until 5:00 pm on Thursday. You need to check in at the reception desk to pick up your lab order form. Check with your insurance for coverage.

Medical Record Transfers: You will need to complete a release of information form before records can be sent or received. You can come into the Clinic and fill out the form or you can go to the Clinic your records are at (if they are not here) and sign a release there. Please allow approximately 2 weeks for the transfer.

DIRECTIONS TO FANNO CREEK CLINIC

Fanno Creek Clinic is located at **2400 SW Vermont St**, Portland, Oregon 97219. Free parking is available in the parking lot directly in front of the building, offering easy access for our patients.

TRIMET INFORMATION: TriMet bus numbers 1, 44, and 45 stop near our clinic. For further information contact TriMet at 503-238-7433 or visit the web site at: <http://www.trimet.org/>.

FROM THE EAST:

1. Starting out from **I-84 W/US-30 W**, merge onto **I-5 South** via the exit on the left toward Beaverton-Salem.
2. Take **Exit 297** toward **Terwilliger Blvd**.
3. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
4. Go **straight** at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
5. Go to the second traffic light and turn **left** onto **Vermont St**.
6. **2400 SW Vermont St** is at the top of the hill on the left.

FROM THE SOUTH:

1. Start out going **north** on **I-5**.
2. Take **Exit 297**. Get into the right lane to avoid getting back on the freeway.
3. Turn **left** at the traffic light onto **Terwilliger Blvd**.
4. Stay in the left lane and turn **left** onto **SW Barbur Blvd/OR-99 W/Pacific Hwy W**.
5. Get into far right lane and turn **right** onto **SW Bertha Blvd** (just before Fred Meyer).
6. Go to the second traffic light and turn **left** onto **Vermont St**.
7. **2400 SW Vermont St** is at the top of the hill on the left.

FROM THE NORTH:

1. Start out going **south** on **I-5**.
2. Take **Exit 297** toward **Terwilliger Blvd**.
3. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
4. Go straight at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
5. Go to the second traffic light and turn **left** onto **Vermont St**.
6. **2400 SW Vermont St** is at the top of the hill on the left.

FROM THE WEST:

1. Start out going **east** on **Sunset Hwy/26**.
2. Take the **405 South Exit**.
3. Merge onto **I-5 South** via the exit on the **left**.
4. Take **Exit 297** toward **Terwilliger Blvd**.
5. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
6. Go **straight** at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
7. Go to the second traffic light and turn **left** onto **Vermont St**.
8. **2400 SW Vermont St** is at the top of the hill on the left.

OR:

1. Start out going **east** on **Beaverton-Hillsdale Hwy**.
2. Turn **right** onto **30th Ave**.
3. Turn **left** at the light onto **Capitol Hwy/Vermont St**.
4. Turn **right** to stay on **SW Vermont**.
5. **2400 SW Vermont St** will be on your right.

FANNO CREEK CLINIC

Adult Health Questionnaire

GENERAL INFORMATION: Completed by patient, please print:

Name: _____ SSN#: _____ Today's Date: _____
Date of Birth: _____ Phone: _____ E-Mail: _____
Emergency Contact Person: _____ Contact Phone Number: _____
Marital Status: S M W D Sep Partner Live With: _____
Occupation: _____ Reason for Visit: _____
Current Concerns: _____

MEDICAL HISTORY: Check current or past problems, indicating date of onset:

- | | | |
|--|---|---|
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Decreased Hearing _____ |
| <input type="checkbox"/> Tuberculosis/TB _____ | <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Emotional Problems _____ |
| <input type="checkbox"/> Thyroid Problems _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Liver Problems _____ | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Heart Trouble/Angina _____ | <input type="checkbox"/> Kidney Problems _____ | <input type="checkbox"/> Heart Attack _____ |
| <input type="checkbox"/> Bladder Problems _____ | <input type="checkbox"/> HIV/AIDS _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Blood Clotting _____ | |
| <input type="checkbox"/> Broken Bones/Osteoporosis _____ | <input type="checkbox"/> Sexually Transmitted Disease _____ | |
| <input type="checkbox"/> Other _____ | | |

SURGICAL HISTORY: Check type of surgery and date of procedure:

- Appendectomy _____ Cataract Surgery _____ Prostate Surgery _____
 Hysterectomy (Full: uterus & ovaries) _____ (Partial: uterus only) _____
 Other: _____

OTHER HOSPITALIZATIONS: Reason & Date: _____

MEDICATIONS: List all medications you are now taking, indicate over-the-counter medications, vitamins & supplements, continue on back if needed:

<u>Name</u>	<u>Strength</u>	<u>How Often</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES: Please list all known drug allergies:

HEALTH HABITS: Indicate all that apply:

Diet: Regular Fast Foods Low Fat Low Salt Vegetarian

Tobacco: Never Smoked Smoked From ___ to ___ Packs/Day Current Packs/Day ___

Alcohol: Never Occasionally Regularly Drinks/Day ___ Heavy In Past Quit ___

Street Drugs: Never Occasionally In Past Type _____ Injection Use : Y N

Sexually Active: Not Active Monogamous Multiple Partners Safe Sex: Y N

Exercise: Unable Rarely Occasionally Regularly Type(s): _____

Seatbelt Use: Never Sometimes Always Automatic Firearms In Home: Y N

FAMILY MEDICAL HISTORY: Indicate health problems & cause of death where applicable. Specify types of cancer, heart disease, diabetes, etc.

<u>MEMBER</u>	<u>LIVING</u>	<u>AGE</u>	<u>MEDICAL INFORMATION</u>
Mother	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Father	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Bro/Sis	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Bro/Sis	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____
Bro/Sis	Y <input type="checkbox"/> N <input type="checkbox"/>	___	_____

CURRENT HEALTH CONCERNS: Check all recent problems:

- | | | | |
|---|---------------------------------------|---|---|
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Chills | <input type="checkbox"/> Constipation | <input type="checkbox"/> Leg Pain (while walking) |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Rash/Itching | <input type="checkbox"/> Easy Bruising/Bleeding |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Bloody/Tarry Stools |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Vaginal/Penile Discharge |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Sexual Problems |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Other: _____ | | |

IMMUNIZATIONS: Please check with date:

Tetanus _____ Hepatitis _____ Pneumovax _____ Other _____

WOMEN'S HEALTH: Please complete:

Last Pap Test: ___ Normal: Y N Last Mammogram: ___ Normal: Y N

Menstrual History: Age of Onset: ___ Regular: Y N Last Menstrual Period: ___

Number of Pregnancies: ___ Number of Live Births: ___ Number of Miscarriages: ___

Current Birth Control Method: _____ Date of Menopause: ___

Fanno Creek Clinic, LLC-Credit and Payment Policy

(Policy effective 12/14/10, may be revised without notice)

Our goal at Fanno Creek Clinic (referred to herein as *the clinic*) is to provide our patients with the best, most current medical care available, in a positive and supportive environment.

Patient Responsibilities

- Patients are responsible for all fees at the time of service.
- Please bring your insurance card and any applicable insurance information to each visit.
- Please advise the front desk of any changes in your name, address, telephone number, insurance coverage, or employer.
- **Referrals:** Referral requests must be obtained by the patient. If you choose to be seen by a specialist, urgent care, or hospital prior to obtaining valid authorization, your visit may not be covered. Please contact our referral department the next business day after being seen at a hospital or urgent care center.
- **Missed Appointments:** The clinic may charge a \$50 fee for established patients who miss two appointments within one calendar year without 24 hour cancellation notice. New patients may be charged a \$75 fee for a missed appointment. Mental health visits are subject to being charged the full fee for any missed appointment.

Payment Information

- All copays are due at the time of your appointment. **You will be billed a \$10 fee if you are seen without paying your copay.**
- All payments are due within 30 days of initial billing statement.
- Insured patients with an unmet deductible of \$500 or more who have not been established patients at the clinic for at least a year will be required to pay a \$100 deposit for any office visit.
- Uninsured patients will be required to pay a deposit of \$100 for all office visits.
- Balances paid **in full** at the time of service are eligible for a 20% discount; any remaining balance will be billed to the patient and/or guarantor.
- **Payment Plans:** Patient balances under \$500 must be paid in full within three months. Patient balances greater than \$500 must be paid in full within six months.
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. Please inform the business office (503-452-0915 x 2073 or option #5) before your visit if you require a payment arrangement or financial assistance.
- If you file for bankruptcy, or your account is assigned to an outside collection agency, you may be required to pay with cash, debit, or credit card **only** for any balances and/or copays for future visits.
- **Automatic Payments:** For patients on payment plans, the clinic offers an automatic payment service via a secure internet system that will automatically deduct monthly payments from your credit or debit card. An email notification will be sent when payments are made to your account. This service is completely secure and leaves no paper trail or visible credit card information. For information please contact the business office at: 503-452-0915 option #4.
- **Psychiatric appointments:** *Charles Kuttner, MD, requests that patients provide in advance a deposit of \$150 (by check or cash), payable by two weeks before the appointment, refundable with 48 hours' notice in the event of cancellation. This helps hold the patient's place.*

Insurance Billing Information

Medicare: Our physicians are participating providers. We will bill Medicare as your primary insurance. In some cases, Medicare will bill your supplementary insurance for you. Please contact your supplementary insurance carrier to make arrangements for supplementary billing.

Oregon Health Plan/Washington Welfare: You must bring your current medical card to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of Social & Health Services, you must obtain a referral to see any specialist.

Secondary Insurance: Fanno Creek Clinic will bill secondary insurance companies. It is the patient's responsibility to make sure the clinic has the current secondary insurance information.

Workers' Compensation: Please notify the front desk if your appointment is related to a claim. In order for us to submit a bill, you will need to provide us with the following information: Name of insurance carrier, your employer name, date of injury, and claim number if you've been assigned one.

Motor Vehicle Accident/Liability Claims: Please notify the front desk if your appointment is related to a claim. We require a \$100 deposit for all visits related to a Motor vehicle accident or Liability claim. Any remaining balance is ultimately the responsibility of the patient. In order for us to submit a bill, you will need to provide us with the following information: Name of responsible insurance carrier, date of injury, and claim number if available.

Agreement

I understand that if my account becomes delinquent, it may be assigned to an outside collection agency. I have read and understand the Fanno Creek Clinic Credit and Payment Policy. My signature below indicates that I accept this policy and agree to abide by the terms for my treatment at Fanno Creek Clinic.

Patient Signature (Guardian signature if patient is a minor):

Date:

Patient Name Printed:

Date of Birth:



FANNO CREEK
C L I N I C

**2400 SW Vermont St.
Portland, Oregon 97219
(503) 452-0915**

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

Fanno Creek Clinic may use and disclose the following information without your authorization for the purpose of and relating to: Treatment, Payment, Health Care Operations, Appointments, Treatment Alternatives, Health-related Products and Services, and the following situations: safety; required by law; research; organ and tissue donation; military veterans; national security and intelligence; workers' compensation; public health risks; health oversight activities; lawsuits and disputes; law enforcement; coroners; medical examiners and funeral directors; and information not personally identifiable. Detailed descriptions of the purposes and situations (not all situations will be described) can be found in our current Privacy Notice. The Clinic requests that you sign below as written acknowledgement of this Notice is required.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.
- We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top right hand side of this page indicates the date of the most current NOTICE in effect.
- You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy.
- If you have any questions, concerns or complaints about the NOTICE of your medical information, please contact Robert Gessele, Clinic Administrator, at 503-452-0915 x 163.

Patient Signature:

Date of Birth:

Date:

Print Patient Name:



FANNO CREEK
CLINIC

August 3, 2010

Dear Fanno Creek Patient:

In our effort to continue to provide high-quality, primary health care to Fanno Creek patients we have converted to paperless statements. Paperless statements will provide Fanno Creek and our patients with a secure, cost effective, time efficient and environmentally responsible billing process. More information can be found on our website at <http://www.fannocreek.com>.

In addition, this will allow Fanno Creek Clinic to focus our time and resources on patient care rather than paper and postage.

Sincerely,

Gregg Coodley, MD, FACP
Medical Director

Please return the below to the clinic front desk or mail to Fanno Creek Clinic, 2400 SW Vermont, Portland, OR 97219

E-mail Address: _____ **Date of Birth:** _____

Print Name: _____

Signature: _____ **Date:** _____

How did you hear about Fanno Creek Clinic?

Dear Patient,

Welcome to Fanno Creek Clinic! We appreciate you choosing us for your healthcare. Please let us know how you found us.

Have you been a prior patient of one of our Providers at a different location? Y N
If so, which Provider? _____

How Did You Hear About Us? Please Check All That Apply:

- Recommendation from Friend or Family Member**
- Advertisement** **Publication Name:** _____
- Yellow Pages**
- News Story** **Publication/Outlet:** _____
- Did a Physician refer you?** **Physician Name:** _____
- Insurance List/Referral**
- Website**
- Clinic Sign**
- Promotional Mailing**
- Other; Please Specify:** _____

Comments or Suggestions:

Thank you for taking the time to fill out this form. Please return it to the receptionist.

Sincerely,

Gregg Coodley, MD