New Patient Packet

Please fill this packet out before your appointment

Once to packet has been filled out you can return it to us one of 3 ways:

Mail:
(Please do not mail your New Patient packet if your appointment is within the next 7 days)

G Street Integrated Health
PO Box 163
Springfield, OR 97477

Secure Email:
Scan your packet and upload the file to our secure email portal. Just go to www.gstih.org and click on Contact Us. You will see a button for secure email on that page where you can send us the scanned document.

-OR-

Just bring the packet with you to your New Patient Appointment

Please give us a call to schedule your New Patient Appointment. Our Patient Access Specialists can answer any questions you have about our Clinic and our Providers.

G Street Integrated Health
1435 G Street
Springfield, OR 97477
541-735-9420

G STREET
Integrated Health

Patient Name:_____ DOB:_____ Date:_____

ALLERGIES (IE: MEDICATIONS, SHELLFISH, IODINE, BEE STINGS):

_____

_____

PAST MEDICAL HISTORY

Please circle any conditions **YOU** have had in the past

GENERAL	**LUNG/PULMONARY**	**GASTROINTESTINAL**	**GENITOURINARY**
Appendicitis	Asthma	Colitis	Kidney Stones
Cancer: Type_____	Chronic Bronchitis	Gallstones	Urinary Tract Infections
Diabetes	Emphysema	Hemorrhoids	Urinary incontinence
Epilepsy	Pneumonia	Hepatitis	Prostate Problems
High Blood Pressure	Tuberculosis	Indigestion/Heartburn	Sexually Transmitted Disease
High Cholesterol	**CARDIOVASCULAR**	Irritable Bowel Syndrome	**PSYCHIATRIC**
Migraine Headaches	Aortic Aneurysm	Liver Disease	Depression
Stroke	Bleeding Disorder	Polyps	Anxiety
Thyroid Problems:	Blood Clots	Ulcers	BiPolar
CHILDHOOD DISEASES	Heart Attack	**SKIN**	Drug Abuse
Chicken Pox	Heart Disease	Acne	Alcoholism
Measles	**MUSCULOSKELETAL**	Bruise Easily	**FEMALES ONLY**
Mumps	Joint Pain	Eczema	Abnormal Pap Smear
Polio	Arthritis	Melanoma	Date of last Pap Smear:_____
Rheumatic Fever	Back Pain	Psoriasis	Age at first menstrual cycle:_____
Scarlet Fever	Muscle Spasms	**EYE/EAR/NOSE/THROAT**	Form of birth control:_____
	Gout	Cataracts	Date of last mammogram:_____
		Glaucoma	
		Ringing in Ears	

Additional Notes:_____

_____

_____

******FORM CONTINUES ON BACK OF PAGE******

Family History: (please list any family members, including grandparents, aunts/uncles, siblings, parents or children)

Cancer (include type): _____

Hypertension: _____ High Cholesterol:_____

Heart disease:_____ Stroke:_____

Blood Clots:_____ Thyroid Problems:_____

Diabetes: _____ Kidney Disease: _____

Alzheimer's/Dementia:_____ Mental illness: _____

Do you have siblings? Yes or No Number of: Brothers _____ Sisters _____

Do you have kids? Yes or No Number of: Sons_____ Daughters_____

Family member:	**Age or year of birth**		**Cause of death**
Father		❑ **Living**	❑ **Deceased**_____
Mother		❑ **Living**	❑ **Deceased**_____
Brother		❑ **Living**	❑ **Deceased**_____
Sister		❑ **Living**	❑ **Deceased**_____
Children:		❑ **Living**	❑ **Deceased**_____

SURGICAL HISTORY: (please include date of surgery or age at the time of surgery)

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

HOSPITALIZATION HISTORY: (Please include date, length of stay, and reason for hospitalization {not ER visits})

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

SOCIAL HISTORY:

Are you: Single Married Engaged Widowed Divorced Separated

Do you drink caffeine? Yes or No How many cups of coffee, tea, soda or energy drinks do you drink a day? _____

Smoking history: Non-smoker Former Smoker Current Smoker Chew Vape

If you smoke or chew: How much? _____ How long have you smoked or chewed: _____

Marijuana use: Yes or No How often? _____

Do you use illegal drugs: Yes or No If so, which one(s): _____

Do you drink alcohol: Yes or No If so, how much:_____

Occupation: _____

Highest level of education completed:_____ Who do you live with:_____

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Name:_____ DOB:_____ Today's date:_____

Please list all medications you are currently taking below.

Medication	Strength	Dosage
Example: Naproxen	500mg	3 times daily
1.		
2.		
3.		
4.		
5.		
6.		
7.		
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28.		
29.		
30.		

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient name:_____Date of birth:_____

_____

(Name of Individual or Organization) (Relationship)

_____

(Address) (Telephone) (Fax)

I authorize the individual or organization listed above to release my medical records and confidential information to G STREET INTEGRATED HEALTH.

I understand my records include medical records, treatment history, progress notes, summaries, medication history, lab reports, hospital, and immunization records. I understand that federal and/or state laws prohibit the re-disclosure of mental health, drug and alcohol, HIV/AIDS diagnoses and treatment information. Specific authorization is required for the release of such information as marked below.

Initial below to authorize these types of records to be released:

_____ Mental health records which may include referral information
_____ HIV/AIDS related information and/or records
_____ Genetic testing information and/or records
_____ Drug and Alcohol records including: diagnosis, assessments, toxicology, psychotherapy/progress notes, treatment, attendance, and referral information

Indicate the reason for release:

_____Continuity of care _____Transfer of care _____ Legal proceedings

By signing below, I understand this agreement, and I am satisfied with any explanations I may have requested and received.

This release is in effect for one year. For behavioral health records, this release only remains in effect for 30 days at the conclusion of services. I understand that information about my care is confidential and protected by state and federal law and I may cancel this authorization at any time. To cancel the authorization, I must provide a request to cancel in writing. The request to cancel this consent will not affect information that was released prior to the date of my cancellation request. I understand the person or organization receiving these records could re-disclose the records and they may not be covered under federal privacy laws.

Any information that has been disclosed from these records is protected by Federal confidentiality rules (42 CFR Part 2). Federal rules restrict the use of a general authorization to criminally investigate or prosecute any alcohol or drug abuse patient.

I have read the entire release and I understand this authorization is voluntary and I may refuse to sign the authorization.

_____

(Signature of patient or guardian) (Type of guardianship) (Date)

G Street Integrated Health
1435 G Street
Springfield, OR 97477

Phone: (541) 735-9420
Fax: (541) 747-9870
Email: contactus@gstih.org

G STREET
Integrated Health

CONSENT TO INFORM

Patient name:_____ Date of birth: _____/_____/_____

I hereby authorize the providers and staff of G Street Integrated Health to inform and/or involve the following people. This can include verbally sharing information about my care plan, appointments, or account status. I understand that this release also allows persons listed below to share information with the providers and staff regarding me.

Name (First and Last)	Relationship	Phone Number

This authorization will remain in effect for one year and will need to be renewed annually. This consent stays in effect unless cancelled in writing by the patient, or a year has passed without renewal. I understand I can cancel this release at any time. Any cancellation will not affect any information that was already released before the cancellation.

By placing my initials here _____, I understand that information specific to drug and alcohol treatment, mental health services, AIDS/HIV, and genetic testing information can be released with this consent as well. I understand information discussed may be re-disclosed by the receiving person and may no longer be covered under federal privacy laws.

By signing below, I understand this agreement, and I am satisfied with any explanations I may have requested and received.

Patient Signature:_____ Date:_____/_____/_____

Authorized Signature:_____ Date:_____/_____/_____

Relationship to Patient: (Example: Parent/Caregiver)

_____

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G STREET
Integrated Health

HIPAA Policy Acknowledgement and Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You confirm by your signature below that you were offered a copy of the Notice and consent to its contents, as well as to be treated in our facility.

The terms of the notice may change in which case you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information for these purposes. You have the right to revoke this consent in writing, however such a revocation cannot be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- You have the right to revoke this consent in writing at any time and all disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent. We may contact you via telephone, email, or send a text to you to confirm appointments. If unable to reach you we may leave a message on your answering machine at home or on your cell phone.

This consent was signed by: _____
(PRINT NAME PLEASE)

Patient Name (If Different from Above):_____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

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Patient Name:_____ **Date of Birth:**_____

FINANCIAL AGREEMENT & ACKNOWLEDGEMENT OF OFFICE POLICIES
G Street Integrated Health

G Street Integrated Health believes that part of good health care practice is to establish and communicate our office and financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our policies.

1. COPAYMENT is expected at the time of your visit. We accept cash, check, Visa, MasterCard, Discover, and Care Credit on select procedures. Payment will include any unmet deductible, co-insurance, co-payment amount, charges not covered by your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. All non-filed services are expected to be paid at the time of service.

2. INSURANCE: We are participating providers with most insurance plans. We will file all of the claims for these plans. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. In order to bill your insurance and to meet filing guidelines we do ask for a copy of your insurance card and a photo ID. If our providers are not listed in your plan's network, you may be responsible for partial or full payment.

3. POLICY ON NON-COVERED SERVICES: This office offers access to many innovative services and procedures some of them are deemed as "not covered" by insurance. In some cases, you will be given an ABN (Advanced Beneficiary Notice) for these types of services/procedures before they are provided/performed. You will be responsible for payment in full at the time of service.

4. **RETURNED CHECKS** will incur a $25.00 service charge.

5. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to G Street Integrated Health for charges not covered by the assignment of insurance benefits and all non-covered charges.

6. **AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize G Street Integrated Health to furnish information to insurance carriers concerning my illness and treatments if requested, and I hereby assign to G Street Integrated Health all payments otherwise payable to me for health care services provided by G Street Integrated Health.

7. **SELF PAY PATIENTS:** Self-pay patients will be identified when they make the initial contact with the office and will be defined as a patient who:

· Has no health insurance coverage of any kind, including federal and state health care programs such as Medicare and Medicaid or other insurance coverage

· Is not eligible for worker's compensation coverage; and

· Has no other responsible party covering the expenses associated with the care received from our clinic. Self-pay patients are required to pay a $100.00 deposit at time of check in. Any additional charges incurred will be collected at check out. All charges are due on the date of service.

8. **BILLING AND COLLECTION FEES:** G Street Integrated Health will submit a claim for payment to your insurance company. In the event your insurance carrier/company denies the services provided, you will be responsible for the payment in full. We appreciate prompt payment in full for any outstanding balance.

9. **DIVORCED PARENTS OF PATIENTS**: By signing below, the adult who signs in a minor child to our practice on the day of service accepts full responsibility for payment. It is not our policy to send bills or records to the other parent/guardian for issue of payment or communication. We will communicate about treatment and payment with the parent present at the time of visit. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

13. **NO SHOW POLICY:** We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than a 24-hour notice.

I have read and understand the practice's office and financial policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____

Signature of Responsible Party Date

Missed Appointment Policy

Due to a high number of missed appointments and same day cancelled/rescheduled appointments, we find it necessary to implement a missed appointment policy. This decision was very difficult for us but we are unable to care for others if our schedules are not full.

Primary Care Policy

- Three missed appointments in a 3 month period may result in dismissal from the practice, at our discretion.

Behavioral Health Policy

- Missed intake with either psychiatry or Care Management will result in permanent dismissal from these programs.
- Two missed appointments for a follow-up appointment in a 90-day period will result in dismissal from the programs.

Same day reschedule or cancellations

We request the courtesy of 24 hours' notice if you need to reschedule or cancel an appointment, so that we may fill that slot from our wait list. Failure to give notice will result in that appointment being considered a missed appointment.

Thank you for your understanding.

_____

(Signature of Responsible Party) (Date)