**Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physician you selected will review your health history and conduct an initial evaluation to determine whether the practice will accept you as a patient.**

*To our patients:*

In order to provide you with our full time and attention when you come for an appointment, we would like to ask you to be aware of the following guidelines.

## Prescription Refills:

- We are implementing a new state of the art e-prescribing system. This works best if you **call your pharmacy directly for <u>any</u> prescription refills,** even if you have no refills left. The pharmacy will contact us directly to get approval for a refill or new prescription.
- Please plan ahead as most local pharmacies request **2-3 business days** to process prescription requests. Pharmacies will typically give you a 2-3 day supply of any non-narcotic medication if you run out without realizing it and you need time for the pharmacy to process the refill.
- For **mail order prescriptions, please contact your pharmacy via their 800 number or website.** Please be sure to contact your mail order pharmacy at least two weeks before you will need the refill. If it is necessary for us to complete forms for your mail order pharmacy, please give us three business days to complete the paperwork.
- Many drug plans will not cover brand name medications, or do so at a much higher cost. We are not always able to obtain prior authorizations for your medications. Generally, you can expect to receive generic medications or pay a higher cost if you prefer the brand name drugs.

## Walk-in appointments:

- We almost always have same day appointments available for urgent needs. Please call ahead to schedule an appointment instead of arriving at our office and requesting to see the physician. Walk-ins impact our ability to see scheduled patients on time.

## Test results:

- We will notify you regarding all lab results either at your appointment or by phone or mail.
- If you have not been contacted with your results two weeks after your appointment, please call our office to follow up.
- Pathology reports, pap smears, and bone density results may take up to four weeks. Please call our office if you have not been contacted after four weeks.
- Please note that if you request lab work prior to your annual appointment, your insurance may not pay for those labs.
- We are happy to provide you with your most recent lab or radiology reports. Please call ahead and we can have that ready for you at the front desk for pick up or mail results to you.

## Copies of your medical record:

- If you would like a copy of your complete medical record, we will need a formal request from you, which must be completed in writing and signed by you or your authorized representative.
- Please allow **30 days for medical record requests.** There is a processing charge to release records to yourself. There is no charge to release records from one doctor to another.

## Co-pays:

- Our contracts with the insurance companies require us to collect your co-payment prior to your seeing the physicians. Please be prepared to pay this when you arrive for your appointment.

## Diagnostic testing:

- Your physician will generally have the report from any diagnostic testing 2 – 3 days following your test. The radiologist who reads the study will notify your physician if there are abnormal results that require immediate follow-up.
- Most CT scans require insurance pre-authorization if not emergent exam.
- MRI, PET, Nuclear Medicine, sleep studies, cardiac studies, and other diagnostic tests require insurance pre-authorization. You will be referred to outside facilities for these studies. We contact the imaging facility of your choice and the will contact you to schedule an appointment. If you have not been contacted after two weeks, please call our office to request assistance in getting your exam scheduled.

**We appreciate you choosing Southern Oregon Internal Medicine for your health care needs.**

**Physician: Dr. Ryan Hungerford**
**Southern Oregon Internal Medicine**
*A Rogue Valley Physicians P.C. Clinic*

**2900 Doctors Park Drive, Suite 200**
**Medford, Oregon 97504**
**Phone: 541-282-2200**
**Fax: 541-282-2237**

**Please fill in the following information completely (Please Print)**

## PATIENT INFORMATION:

**TODAY'S DATE** _____

NAME _____ NICKNAME_____
LAST FIRST MIDDLE

HAVE YOU EVER RECEIVED MEDICAL TREATMENT UNDER ANOTHER NAME: [ ] YES [ ] NO

IF YES, UNDER WHAT NAME? _____ _____

SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____/_____/_____ GENDER _____

PHYSICAL
ADDRESS_____ _____
STREET ADDRESS CITY STATE ZIP

MAILING ADDRESS
IF DIFFERENT THAN ABOVE_____
PO BOX CITY STATE ZIP

RACE: _____ LANGUAGE _____ HISPANIC OR LATINO [ ] YES [ ] NO

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED LEGALLY SEPARATED LIFE PARTNER WIDOWED

HOME PHONE_____ EMAIL_____ CELL PHONE_____

EMPLOYED: YES NO EMPLOYER_____ WORK PHONE _____

## SPOUSE INFORMATION:

NAME _____ HOME PHONE: _____
LAST FIRST MIDDLE

DATE OF BIRTH _____/_____/_____ SOCIAL SECURITY # _____-_____-_____

EMPLOYER _____ WORK PHONE _____ OCCUPATION _____

## INSURANCE INFORMATION -- <u>PLEASE PRESENT CURRENT INSURANCE IDENTIFICATION CARD(S) TO RECEPTIONIST</u>.

**PRIMARY COVERAGE:**

HEALTH INSURANCE: _____ Policy # _____ Group # _____

POLICY HOLDER'S NAME _____ DOB _____/_____/_____ SEX _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

**SECONDARY COVERAGE:**

HEALTH INSURANCE: _____ Policy # _____ Group # _____

POLICY HOLDER'S NAME _____ DOB _____/_____/_____ SEX _____

EMPLOYER _____ RELATIONSHIP TO PATIENT _____

## MEDICAL TREATMENT RESULTING FROM AN ACCIDENT (Please Complete Accident Report)

I AM RECEIVING MEDICAL TREATMENT AS A RESULT OF AN ACCIDENT: [ ] YES [ ] NO

IF YES, WHAT TYPE OF ACCIDENT? [ ] MOTOR VEHICLE [ ] WORK ACCIDENT [ ] OTHER _____

## INFORMATION FOR PHYSICIAN:

EMERGENCY CONTACT: _____ PHONE:_____RELATIONSHIP:_____

WHO IS YOUR **PRIMARY CARE PHYSICIAN**? _____ PHONE #_____FAX#_____

HOW DID YOU HEAR OF OUR CLINIC?_____ _____

IF SELF-REFERRED, HOW DID YOU CHOOSE US: [ ] OUR WEBSITE [ ] PHONE BOOK [ ] OTHER_____

**Southern Oregon Internal Medicine**
2900 Doctors Park Drive, Suite 200 | Medford, OR 97504
Phone: (541) 282-2200 | Fax: (541) 210-5195

# HEALTH HISTORY QUESTIONNAIRE
## Diabetes, Thyroid, and Endocrine Disorders

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

| Name (Last, First, M.I.): | Date of birth:<br>□ Male □ Female |
|---|---|
| Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed | |
| Referring doctor: | Primary provider: |
| Other doctors you see: | Preferred pharmacy for medications: |
| What is the reason for your referral: | |

## PERSONAL HEALTH HISTORY

| Cardiac Stress Test Date:<br>□ *Have not had test* | DXA/Bone Density Date:<br>□ *Have not had test* |
|---|---|

List any medical problems that other doctors have diagnosed. (*Check common health problems from the list below or fill in as needed.)*

□ Heart attack or CHF □ Heart stent □ Atrial fibrillation □ Diabetes

□ Hypertension □ High Cholesterol □ Arthritis □ Asthma

□ Lung disease □ Cancer □ Kidney stones □ Kidney disease

□ Foot ulcers □ Stomach ulcers □ Osteopenia or osteoporosis

□ Obstructive sleep apnea □ Neuropathy □ Stroke

Other:

Have you ever had radiation therapy to your neck (for cancer or skin condition, *not* dental x-rays)?
□ Yes □ No

**Surgeries**

| Year | Health condition leading to surgery | Surgery performed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| List your prescribed drugs and over-the-counter drugs and/or nutritional supplements | | |
|---|---|---|
| Medication Name | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| **Allergies to medications** | | |
| Name of drug | Reaction you had | |
| | | |
| | | |
| | | |

| HEALTH HABITS | | | | |
|---|---|---|---|---|
| ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL | | | | |
| **Exercise** | ◻ Sedentary (no exercise) | | | |
| | ◻ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | |
| | ◻ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min) | | | |
| | ◻ Regular vigorous exercise (i.e., work or recreation, 4x/week for 30 mins or more) | | | |
| **Diet** | Are you following a diet? ◻ Yes ◻ No If so, which one? | | | |
| | # of meals you eat in an average day? | | | |
| | Rank salt intake | ◻ High | ◻ Medium | ◻ Low |
| | Rank fat intake | ◻ High | ◻ Medium | ◻ Low |
| **Caffeine** | ◻ None | ◻ Coffee | ◻ Tea | ◻ Cola |
| | # of cups / cans per days | | | |
| **Alcohol** | Do you drink alcohol? | | | ◻ Yes ◻ No |
| | If yes, what kind? | | How many drinks per week? | |
| | Are you concerned about the amount you drink? | | | ◻ Yes ◻ No |
| | Have you considered stopping? | | | ◻ Yes ◻ No |
| | Have you ever experienced blackouts? | | | ◻ Yes ◻ No |
| | Are you prone to “binge” drinking? | | | ◻ Yes ◻ No |
| | Do you drive after drinking? | | | ◻ Yes ◻ No |
| **Tobacco** | Do you use tobacco? | | | ◻ Yes ◻ No |
| | ◻ Cigarettes pks/day | ◻ Chew - #/day | ◻ Pipe - # /day | ◻ Cigars - # /day |
| | # of years | ◻ Or year quit | | |
| **Drugs** | Do you currently use recreational or street drugs? | | | ◻ Yes ◻ No |
| | Have you ever given yourself street drugs with a needle? | | | ◻ Yes ◻ No |
| **Other health habits not covered in questions above:** | | | | |

| FAMILY HEALTH HISTORY | | | | | |
|---|---|---|---|---|---|
| | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** | | **AGE** | **SIGNIFICANT HEALTH PROBLEMS** |
| **Father** | | | **Children** | ☐ M<br>☐ F | |
| **Mother** | | | | ☐ M<br>☐ F | |
| **Sibling** | ☐ M<br>☐ F | | | ☐ M<br>☐ F | |
| | ☐ M<br>☐ F | | | ☐ M<br>☐ F | |
| | ☐ M<br>☐ F | | Grandmother *Maternal* | | |
| | ☐ M<br>☐ F | | Grandfather *Maternal* | | |
| | ☐ M<br>☐ F | | Grandmother *Paternal* | | |
| | ☐ M<br>☐ F | | Grandfather *Paternal* | | |

| EDUCATION AND OCCUPATION |
|---|
| Where were you born? City: State: |
| What is your highest level of education? |
| What is your employment status? (What was your last job?) |
| List some of your favorite hobbies: |

| REVIEW OF SYSTEMS | | |
|---|---|---|
| **GENERAL** | **Yes** | **No** |
| Do you worry a lot about your health? | | |
| Do you usually feel tired or worn out? | | |
| Do you feel depressed a lot of the time? | | |
| Are you sensitive to cold or hot temperatures? | | |
| Have you recently been drinking more fluids? | | |
| Have you had unusual weight loss or gain? | | |
| Do you have swollen glands or lymph nodes? | | |
| **SKIN** | | |
| Any change in the color of your skin? | | |
| Skin rashes or itching? | | |
| Dry skin? | | |
| Skin growths? | | |
| Sores or wounds that don't heal? | | |

| **EYES** | **Yes** | **No** |
|---|---|---|
| Cataracts? | | |
| Glaucoma? | | |
| Diabetic eye damage? | | |
| Changes in vision? | | |
| Blurry vision? | | |
| Double vision? | | |
| Tunnel vision? | | |
| **EARS, NOSE, THROAT AND NECK** | | |
| Hearing trouble? | | |
| Ringing or buzzing in your ears? | | |
| Change in your voice or hoarseness? | | |
| Thyroid enlarged or neck mass that you can feel? | | |
| **RESPIRATORY SYSTEM** | | |
| Bothersome cough? | | |
| Difficulty breathing? | | |
| Wheezing or whistling in chest? | | |
| Do you snore? | | |
| **HEART AND BLOOD VESSELS** | | |
| Pain, tightness or pressure in your chest? | | |
| Have you been told your EKG is abnormal? | | |
| Swelling of feet or ankles? | | |
| Heart beat fast or irregular? Palpitations? | | |
| Cramps in legs when walking? | | |
| Awakened at night by shortness of breath? | | |
| Fingers or toes cold, numb, blanched or bluish? | | |
| **GASTROINTESTINAL SYSTEM** | | |
| Recent change in appetite or eating habits? | | |
| Difficult swallowing? | | |
| Frequent indigestion and/or heartburn? | | |
| Frequent nausea or vomiting? | | |
| Constipation? | | |
| Loose stools or diarrhea? | | |
| **BONES AND JOINTS** | | |
| Burning or pain when you urinate? | | |
| Frequent urination? | | |
| Pass urine at night? | | |
| Blood in the urine? | | |
| Urinary infections? | | |
| Kidney stones? | | |
| **REPRODUCTIVE SYSTEM (Men)** | | |
| Sterilization? Vasectomy? | | |
| Problems with your penis or testicles? | | |

| **REPRODUCTIVE SYSTEM (Men) CONTINUED** | Yes | No |
|---|---|---|
| Prostrate trouble? | | |
| Trouble getting or maintaining an erection? | | |
| Loss of libido (sex drive)? | | |
| **REPRODUCTIVE SYSTEM (Women)** | | |
| At what age did your menstrual periods start? | | |
| How often do your periods occur? | | |
| How long do they last? | | |
| Are they regular? | | |
| Bloating or weight gain before your periods? | | |
| Sterilization? Tubes tied? | | |
| Are you pregnant or breastfeeding? | | |
| Do you have hot flashes | | |
| Loss of libido? Interested in sex? | | |
| Have you had any abortions or miscarriages? | | |
| Lumps in your breasts? | | |
| Discharge from nipples? | | |
| **NERVOUS SYSTEM** | | |
| Frequent or severe headaches? | | |
| Spells of dizziness, faintness or lightheadedness? | | |
| Change in smell or taste? | | |
| Loss of memory? | | |
| Epilepsy, convulsions, seizures? | | |
| Numbness or tingling in arms, legs or feet? | | |
| Weakness of muscles? | | |

Signature

Date

**Southern Oregon Internal Medicine**
*A Rogue Valley Physicians, P.C. Clinic*

# Financial Policy

Patient Name:_____ Date of Birth:_____

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we require you to read and sign prior to your visit with us. Please be sure to complete both pages.

## REGARDING YOUR INSURANCE

It is not possible for a medical practice to become familiar with the details of every health insurance plan it encounters. It is the responsibility of the patient to be aware of what is covered and what is not covered by your insurance, and how much the patient responsibility for services will be. We will submit insurance claims as a courtesy to our patients with insurance, and will help you in every way possible to obtain your maximum insurance benefits. However, you are responsible for our charges. We ask that you pay any deductible, co-pay and balance owed at the time of service. Please remember that we can only estimate the amount to be paid by an insurance company as they make payments based on their fee schedule. Their fee schedules may differ from our charges. While we attempt to help you in every way possible to obtain your maximum allowable insurance benefits, the insurance contract is between you and your insurance company and does not replace your responsibility for your account. If your insurance company has not paid your claim within 45 days, we will ask you to pay the balance in full. We will not be calling your insurance prior to your visit to verify your coverage.

## SECONDARY INSURANCE

Having more than one insurer does not necessarily mean that your services are covered at 100%. We may bill your secondary carrier as a courtesy. You are responsible for any balance after insurance(s) has cleared.

## USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

*Continued…*



**Southern Oregon Internal Medicine**
2900 Doctors Park Drive, Medford OR 97504
Phone: 541-282-2200 Fax: 541-282-2237
www.SOInternal.com A Rogue Valley Physicians, PC Clinic

**FOR PATIENTS WITHOUT INSURANCE**

We ask that our patients that do not have insurance pay at least ½ of their charges at the time of service. The remainder of this balance must be paid in 2 equal monthly payments. Special arrangements may be made with the advance approval of the billing department. Please let the receptionist know if you need to speak to our billing staff.

**OREGON HEALTH PLAN PATIENTS**

If you are an Oregon Health Plan/Medical Card patient, we require that you show your current medical card before each visit and that you are currently assigned to the appropriate physician. We will re-schedule your appointment if you fail to comply with this policy and do not present with your current card. We are unable to call your insurance prior to your visit to verify your coverage.

**SERVICE CHARGES**

A fee of $25.00 will be assessed to your account for any check returned due to non-sufficient funds. A fee of $20.00 may be assessed to your account for a missed appointment.

**WE ACCEPT PERSONAL CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND CASH**

Thank you for your attention to our financial policy. Please let us know if you have any questions or concerns.

**I have read the Financial Policy. I understand and agree to the terms of this Policy. In addition, I authorize Southern Oregon Internal Medicine to release any medical information necessary to process a claim. I hereby assign payment directly to Rogue Valley Physicians, PC all payments due from my insurance company. I understand that I am financially responsible for the charges and should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient.**

_____ _____

Patient (or Legal Guardian) Signature Date



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Southern Oregon Internal Medicine
2900 Doctors Park Drive
Medford, OR 97504

# Authorization to Release Medical Information

Patient:_____ Birth date:_____

**I consent to the release of Medical Information (records):**

**To:**

**Dr. Ryan Hungerford**
2900 Doctors Park Drive
Medford, OR 97504
Phone: (541) 282-2200
Fax: (541) 210-5195

**From: (Physician, Clinic, or Person Include phone &/or fax #)**

_____
_____
_____
_____
_____

**Information to be released:**

____ Standard Problem List, Medication Summary, Progress Notes, Health History, Immunization Records, Letters, X-ray & Laboratory Reports. From Date: _____ To Date: _____
____ X-ray reports only. Date(s): _____
____ Laboratory and Pathology reports only. Date(s): _____
____ Other tests or studies (list type of test/study and date performed): _____
____ Other (specify): _____

**In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record. * (Initial if release is authorized)**

____ Drug and alcohol abuse
____ Information related to diagnosis/treatment of HIV.

**Please note that a separate release is required for Behavioral Health Information.**

**Purpose of Disclosure:**

_____
_____

This authorization is valid for six months after the date of signature. The authorization may be revoked any time (but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

_____ _____
Signature of patient or legally authorized representative Date

SOUTHERN OREGON INTERNAL MEDICINE

## Telephone Disclosure form

Patient Name (please print)_____ DOB:_____

Welcome to Southern Oregon Internal Medicine. We want to be sure we handle your personal medical information in a way that is acceptable to you. We appreciate your taking the time to fill out this form. If you have a special request, be sure to let your receptionist know.

**It is okay to leave information on my answering machine:** _____Yes _____No

**Please indicate which medical information you authorize to be disclosed via the telephone from our office:**

_____Appointments _____Pathology Results

_____Lab Results _____Prescription/Samples Information

_____EKG Results _____Mammogram Results (men may also need this…)

_____X-Ray Results _____ALL OF THE ABOVE

**It is okay to disclose my personal health information to the following the following individuals:**

_____Spouse (Name): _____

_____Significant Other (Name): _____

_____Family Members or Friends (Names):_____

_____

_____

_____Caretaker (Name): _____

_____Do not disclose my health information to anyone

_____ _____

Patient Signature Date

Thank you. If you need to get in touch with our office, remember that we may be busy serving other patients, but will make every effort to return calls from you within 24 business hours.

# ENDOCRINOLOGY APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your specialized medical care to Dr. Hungerford, Southern Oregon Internal Medicine. When you schedule an appointment with Dr. Hungerford, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us ample time to schedule other patients who are waiting for an appointment. Please acknowledge our Cancellation/No Show policy below:

- Any established patient who fails to show or contact our office to cancel an appointment with at least a 24 hours' notice of the appointment time, will be considered a no-show and charged a $95.00 fee.

- Any new patient that no shows or cancels their initial visit less than 24 hours of their appointment time will be charged a $150.00 fee.

- The fee is charged to the patient, not to their insurance company, and will need to be paid before the patient is rescheduled.

- As a courtesy, automated appointment reminder calls at 2 weeks prior to the appointment, 2 days prior to the appointment, and if there is a cell phone listed, a text message 2 hours before the visit time is sent. If a reminder call is not received, the above policy remains in effect.

We do understand there are times when an unforeseen event occurs, and you are not able to keep your appointment. If you should experience such an event, please call our office manager to discuss the possibility of waiving the no-show fee. You can contact our office 24 hours a day, 7 days a week, and should it be after regular business hours, you may leave a message.

Dr. Hungerford, MD, FACE, ECNU
Southern Oregon Internal Medicine
541-282-2200

I have read and understand the Cancellation/No Show policy.

_____ _____

Signature Date

_____

Print Name