☐ New Patient ☐ Update ☐ Address Change ☐ Name Change

BAY CLINIC, LLP

1750 Thompson Rd Coos Bay, OR 97420
541.269.0333

PATIENT INFORMATION

Completion of this form in its entirety is required before time of visit/treatment.

Patient Name: _____ Preferred Name: _____
Last First Middle
Other Names Used (Birth/Maiden/Legal Name Change): _____

Date of Birth: _____ SSN: _____ Race: _____ Ethnicity: _____

Legal Sex: _____ Gender Identity: _____ Sex Assigned at Birth: ____ Pronouns: _____ Preferred Language: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Address (If Different): _____ Email Address: _____

Home Number: _____ Cell Number: _____ Okay to Leave Message? YES or NO

Employer: _____ Employer Number: _____

Spouse/Significant Other (If Applicable): _____ Date of Birth: _____

Number: _____ Employer: _____ SSN: _____

☐ **CHECK BOX IF SELF**
Responsible Party Name (Parent/Legal Guardian): _____ Date of Birth: _____

Relationship to Patient: _____ Phone: _____ SSN: _____

Employer: _____ Employer Number: _____

EMERGENCY CONTACTS

Contact Name:_____ Relationship:_____ Phone Number:_____

Contact Name:_____ Relationship:_____ Phone Number:_____

A copy of your Insurance Card (front & back) is required to bill your insurance.

Patient Primary Insurance: _____ Policy Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

Patient Secondary Insurance: _____ Policy Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: _____

If your visit is related to an MVA or Workers Compensation Claim, please let the receptionist know for additional forms.

I acknowledge that I am financially responsible for all charges, whether or not they are covered by insurance for this and subsequent visits. I will be responsible for any and all collection agency fees up to 50% of the amount placed with the collection agency. In the event legal action is sought for collection of my accounts, I will also be responsible for any and all fees associated with court costs, garnishment, and/or attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of benefits.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

Revised 5.12.2023

BAY CLINIC, LLP

1750 Thompson Rd Coos Bay, OR 97420
541.269.0333
PHYSICIANS AND SURGEONS

1750 Thompson Rd
Coos Bay, OR 97420

Print Patient Name: _____

The following disclosures are made in compliance with the Federal Truth in Lending Law.

The Bay Clinic, LLP will extend credit to a patient with the understanding that:

ALL CHARGES ARE DUE AT THE TIME OF SERVICE

I hereby authorize The Providers of Bay Clinic, LLP to furnish the insured's insurance company all information which said Insurance Company may request.

I hereby assign to the Providers of Bay Clinic, LLP all insurance proceeds to which I am entitled for medical and/or surgical expense relative to the services performed. I understand that this assignment does not relieve me from responsibility for charges not paid by my insurance company.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

ACKNOWLEDGMENT AND CONSENT

I understand the **Bay Clinic, LLP** located at 1750 Thompson Rd., Coos Bay, OR (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 other related information to insurance companies or other who may be responsible to pay for some or all of my 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 quality, 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** and describes the use 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. 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 the manner described in the Notice of Privacy Practices, and I understand that This Practice 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.

Print Patient Name: _____

Patient Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

BAY CLINIC, LLP

1750 Thompson Rd
Coos Bay, OR 97420
541.269.0333

Right of Access for Family Member/Friend

HIPAA Privacy Release

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

I authorize my medical service providers to disclose and release my protected health information (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing). This information may be released to:

	Name	**Relation**	**Phone Number**
1.			
2.			
3.			
4.			
5.			

Specific information **NOT** to be disclosed:

_____

☐ Check box if declining.

*This **Release of Information** will remain in effect until terminated in writing.*

Patient Signature: _____ **Date:** _____

Parent or Legal Guardian Signature: _____ **Date:** _____

Consent for Bay Clinic, LLP Care Coordinators

By signing below, I am giving Bay Clinic, LLP Care Coordinators permission to disclose my Protected Health Information (PHI) for continuation of care.

Examples of who Bay Clinic, LLP Care Coordinators may disclose my information to are but not limited to:

- Food Pantries
- Meals on Wheels
- Bay Cities Brokerage
- South Coast Business Employment Corporation

Examples of PHI Bay Clinic, LLP Care Coordinators may disclose but not limited to:

- Name
- Address
- Date of Birth
- Insurance

Bay Clinic, LLP Care Coordinators will **NOT** disclose any of our patients diagnoses and/or any physician notes.

Patient Signature: _____ **Date:** _____

Parent or Legal Guardian Signature: _____ **Date:** _____

Revised 5.12.2023