Todd Gillingham MD
FAMILY PRACTICE
17200 NW Corridor Ct. Ste 110, Beaverton OR 97006 PH: 503-614-8633 Fax: 503-614-8635

PATIENT REGISTRATION FORM

Patient Name:

Date of Birth: Gender: Marital Status:

Race: Ethnicity: Language:

Address:
(Street, City, State, Zip)

Home Phone: Cell Phone:

E-mail Address: Employer:

RESPONSIBLE PARTY: (Complete only if different from patient)

Responsible Party Name:

Date of Birth: Gender: Relation to Patient:

Address (if different from patient):
(Street, City, State, Zip)

Home Phone: Cell Phone:

E-mail Address: Employer:

WHO TO CALL IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Cell Phone: (_____) _____-_____

PRIMARY INSURANCE INFORMATION

Plan Name: Relation to Patient:

Member I.D. Number: Group Number:

Policy Holder Name:

Policy Holder DOB: Policy Holder Gender:

Plan Address:

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SECONDARY INSURANCE INFORMATION

Plan Name: Relation to Patient:

Member I.D. Number: Group Number:

Policy Holder Name:

Policy Holder DOB: Policy Holder Gender:

Plan Address:
(Street, City, State, Zip)

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y _____ N_____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

ASSIGNMENT OF BENEFITS

I attest that the information I have provided to Todd Gillingham MD, LLC is correct and true to the best of my knowledge. I hereby assign any medical and/or surgical benefits to Todd Gillingham MD, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I further authorize Todd Gillingham MD, LLC to release all information to secure payment.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any physician, hospital, pharmacy, or medical care facility to provide all information regarding my medical or pharmaceutical history and treatment to Todd Gillingham MD, LLC. I furthermore will allow my pharmacy to supply verification of benefits. I also authorize Todd Gillingham MD, LLC to release my medical information to other physicians as needed to facilitate treatment.

Signature: _____ Date: _____

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Medical History

Patient Name:	Date of Birth:	Age:	Today's Date:
	Birth Place:	Gender:	

Patient's Medical History: Has the patient ever had? (Circle all that apply)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Immediate Family's Medical History: Blood relatives currently have or have ever had? (Circle all that apply)

Alcohol/Drug Abuse	Emphysema	High Blood Pressure	Psychiatric
Asthma	Epilepsy	High Cholesterol	Seasonal Allergies
Cancer	Heart Disease	Infectious Disease	Stomach Disorders
Colitis	Headaches	Kidney Disease	Thyroid Disease
Diabetes			

Family History:

	Age(s)	Living?	Age at Death	Cause of Death or Current Condition
Father	_____	Y / N	_____	_____
Mother	_____	Y / N	_____	_____
Brothers	_____	Y / N	_____	_____
Sisters	_____	Y / N	_____	_____
Child(ren)	_____	Y / N	_____	_____

List All Surgeries and Serious Illnesses:

Surgery/Serious Illness	Year	Hospital/Location
_____	_____	_____
_____	_____	_____

Medication/Food Allergies:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Food	Reaction
_____	_____
_____	_____
_____	_____

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Medications you are Currently Taking: (Including birth control, over the counter, and herbal medications).

Medication	Dose	Frequency

Dates of your last:

Blood test/Cholesterol Level:		EKG:	
Pap Smear:		Chest X-ray:	
Prostate Check:		Mammogram:	
Physical Exam:		Tetanus Booster:	
Glaucoma Check:		Pneumovax:	
Sigmoidoscopy/Stool Check:		Skin Test for TB:	

Social History:

Marital Status: _____ Occupation: _____ Spouse's Occupation: _____

Do you smoke? Y or N
If yes, age you started smoking: _____ Year you quit: _____ Packs per day: _____

Illicit drug use? ☐Never ☐Remote ☐Recent ☐Current

How much caffeine do you drink? (Average number of drinks per day)
None 1 2 3 4 ≥5

How much alcohol do you drink? (Average number of drinks per day)
None Rare (<1) Moderate (1-2) High (>2)

Do you exercise?
None Occasional Moderate Frequent

Seat Belt Use? Y or N Smoke Detector in Home? Y or N

Bike Helmet Use? Y or N Fire Extinguisher in Home? Y or N

Have you ever completed an Advance Directive or Living Will? Y or N

Have you requested your medical records from your previous Physician's office? Y or N
If not, Please request a Release of Records form at our front desk.

Thank you for taking the time to complete this form.

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Clinic Family and Friends Authorization Form

Patient Name: _____ Date of Birth: _____

As a patient of Todd Gillingham, MD, LLC, would you like to elect to have others involved in your health care? Without your prior approval, we cannot discuss any medical information with family or friends. Please list the names of those you would like listed as being involved in your health care. This information can be changed or revoked with your permission at any time.
I give permission for information related to my current health status to be discussed with:

Name	Relationship	Telephone

The following people are indicated as individuals who can make medical decisions on my behalf if I am unable to make them on my own.

Name	Relationship	Telephone

I understand that this might include such information as: diagnosis, prognosis and treatment plans, medications, discharge and instruction plans, diagnostic test results, appointment reminders, medical billing, insurance, and any other medical information relevant to my care.

_____ _____
Signature Today's Date

☐ I decline to have my medical information discussed with family or friends.

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AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: _____

_____
(Name and Address of physician/medical group we are requesting your records from)

_____ _____
(Physician/medical group phone number) *(Physician/medical group fax number)*

To use and disclose a copy of medical information described below, regarding:

_____
(Name of Patient) *(Date of Birth)*

Consisting of *(Check appropriate box)*:

□ Full Records

-or-

□ Specific Information Only *(Circle all below that apply)*

History & Physical Medications/Therapy Lab/Path/EKG X-ray/Ultrasound

Operative Reports Accident & Injury Immunizations Other: _____

Protected or sensitive information: I understand that certain information cannot be released with specific authorization as required by State/Federal law. BY INITIALING, I authorize release of the following protected or sensitive information:

____ Drug Abuse Diagnosis/Treatment ____ Mental Health Treatment

____ Alcoholism Diagnosis/Treatment ____ Sexually Transmitted Diseases

____ AIDS/HIV Test Results including related high risk behaviors

Please Fax Records to: Todd S Gillingham MD, LLC at 503-614-8635

for the purpose of: Consultation and/or Treatment

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ Date:
(Patient)

By: _____ Date:
(Patient representative)

Description of Representative's Authority:_____

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Notice of Privacy Practices
Effective Date: November 5, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All of us at Todd S Gillingham MD, LLC take our responsibility to safeguard your protected health information very seriously. We value your trust as an important part of our ability to provide you with the best possible medical care. We also recognize that individual privacy is rapidly eroding in our culture and we are dedicated to defending your right to a confidential relationship with your physician. This notice is intended to inform you of how we protect, use, and disclose your information, as well as to explain your right to control these disclosures. We will only disclose your information in the following instances:

1. We may disclose your information to coordinate your medical care.
2. We may also disclose your information to ensure that you receive insurance benefits.
3. We may disclose your information internally to enhance the operations of our practice. This includes our commitment to reviewing the quality of care we provide.
4. We may disclose your information to comply with a limited number of legal requirements as outlined in this notice.

Additional information regarding each of these disclosures is provided in this notice. Regardless, we will only disclose the minimum amount of information necessary for the purpose for which it was requested.
Like many legal documents, it may appear at first glance that this notice is more about permitting disclosures than about limiting them. However, we believe it is important that you are fully informed of the various reasons we might disclose your information.

Our Duties
We are required by law to keep your information private. We must also provide you with notice of our practices and legal duties that relate to your information. We are required by law to abide by the terms of this notice of privacy practices. We may need to revise our privacy practices from time to time. We expressly reserve the right to change the terms of our notice of privacy practices, and to make the new terms effective for all information covered by our notice. If such changes occur, we will let you know of the new terms by providing a copy of the changes in our lobby.

Consent to Disclosures
When we begin your care, we will ask you to sign an agreement that permits disclosures of your information only for the purposes outlined in this notice. Because such disclosures are important to coordinate your medical care, we require your consent to access our services. This notice provides additional information regarding these disclosures and any disclosures that we may make without your consent. Before making a disclosure for any purpose not listed in this notice, we will request a written authorization from you.

Your Privacy Rights
Please note that you are entitled to very specific rights regarding the use and disclosure of your information. We have listed your rights below.

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Right to Notice of Privacy Practices
You have the right to be notified of our policies regarding our use and disclosure of your information. This document provides you with that notice.

Right to Request Restriction of Uses and Disclosures
You have the right to request restriction on the use and disclosure of your information. If you request such a restriction, we may choose to either comply with your request or terminate your care here. In certain instances, your choice to restrict the disclosure of information may invalidate your insurance coverage, and we may require that you execute both a waiver of insurance benefits and a payment agreement in order to receive care. If you have been injured on the job and have filed a workers' compensation claim, Oregon law forbids limiting disclosures to your carrier or self-insured employer. Generally, we will not agree to requests to limit disclosure of your information related to (a) the coordination of your medical care, (b) the internal operations of our practice, or (c) legal requirements. It is simply too difficult to comply with such restrictions. To make a request to limit the disclosure of your information, please contact our Medical Records Department at 503-614-8633.

Right of Access to Inspect and Obtain a Copy of Protected Health Information
You have the right, after providing us with reasonable notice, to visit our office and inspect our medical records regarding your care. You may request that our communication with you be confidential; for example, you could request that we only call you at home, not at work. You also have the right to receive copies of our medical records regarding your care. Before your inspection or receipt of our records, your physician will review your record. Your physician has the right to substitute a summary of our record if, in his or her opinion, release of the record would harm you. This situation is very rare in our practice, and you will generally receive unrestricted access to your medical record. We do not permit inspecting or copying medical records we receive from other providers, but we can assist you in identifying such providers so that you may request their records directly. To request an inspection or copy of your record, please contact our Medical Records Dept. at 503-614-8633.

Right to Amend Protected Health Information
If you believe that our records contain errors, you may make a written request that they be amended. We reserve the right to review your request and decline to amend the record. Generally, we will agree to place a copy of your proposed amendment in the record even when we do not agree to amend the record itself. Please contact our Medical Records Department 503-614-8633 to request an amendment.

Right to an Accounting Disclosure of Protected Health Information
We record each time we disclose your information. You have the right to request an accounting of each disclosure. Please contact our Medical Records Department 503-614-8633 to request an accounting of disclosures.

Complaints and Investigations
We have developed procedures for investigating any complaints or concerns you may have regarding our use and disclosure of your information, or any other complaint you may have regarding our services. The law allows you to contact the Secretary of the Department of Health and Human Services with complaints about our use and disclosure of information. You may also contact our on-site Privacy Officer, who is dedicated to investigating complaints regarding the use and disclosure of information in our care.

Regardless of whom you contact, we will not, and legally cannot, retaliate against you for any such complaint. Our Privacy Officer can be reached at 503-614-8633.

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Types of Uses and Disclosures of Your Protected Health Information

We may disclose your information for the following purposes without your consent.

For Treatment Purposes
We may disclose information needed for the provision, coordination, or management of health care and related services, including the coordination between our office and a third-party, such as a consultation between medical providers or a referral from our office to another provider. For example, we may send a report detailing our diagnosis and treatment to your primary care physician, your treating physical therapist, or to another physician involved in your care.

For Payment Purposes
To obtain reimbursement from your insurer, we may be required to disclose your information. This may be necessary for determining your eligibility or coverage and the adjudication of claims, billing, claims management, and collections activities. We may also be required to disclose your information to your insurer for review of the medical necessity, coverage, appropriateness, or justification of our charges. For example, many insurers require that we submit copies of the chart as a condition of reimbursement for our services. The process of prior authorization for specific diagnostic or surgical procedures represents another example in which we may disclose your information to gain your insurer's approval to proceed with a recommended course of care.

For Health Care Operations Purposes
We may disclose your information within our organization for the purposes of:

1. Quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines.
2. Reviewing the competence or qualifications of our providers.
3. Conducting, or arranging for, medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.
4. Managing and operating our practice, including formulary development and administration and general business management activities such as customer service and complaint resolution.

One example of such disclosure is the periodic chart review conducted by our Peer Review Committee to ensure the quality of our services.

Other Purposes
There are a variety of other purposes for which we may, or may be required to, use or disclose information about you without your written consent or authorization. These include disclosures:

(A) **for public health activities**, such as reporting to a public health agency, as authorized by law; reporting of disease, injury or vital events, such as birth or death; and reporting of adverse events to the Food and Drug Administration;

(B) **about victims of abuse, neglect, or domestic violence**, as required by law;

(C) **to a health oversight agency**, as authorized by law; including but not limited to audits; civil, administrative, or criminal investigations; licensure or disciplinary actions, or other activities necessary for appropriate oversight of the health care system; and government benefit programs;

(D) **for judicial and administrative proceedings**, in response to a court order or valid subpoena. If we receive a subpoena for your information, we will require that the party submitting the subpoena provide us with evidence that you have been provided with adequate notice and the opportunity to object to the release of your information prior to disclosure;

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(F) **for law enforcement purposes**, in compliance with, and as limited by a court order, a court-ordered warrant, a subpoena, a summons issued by a judicial officer, and a grand jury subpoena; or in emergency situations or when criminal conduct has occurred on our premises, subject to limitations as provided by law;

(F) **to coroners and medical examiners**, to identify a deceased person or determine a cause of death;

(G) **for organ, eye, or tissue donation purposes,** when such donations have been authorized;

(H) **to avert a serious threat to health or safety** of a person or to the public;

(I) **for armed services personnel and veterans**, to determine an individual's eligibility for benefits;

(J) **for workers' compensation**, as provided by state law;

(K) **for inmates** of a correctional institution or under custody of a law enforcement official, to provide you with health care and for the safety and security of the correctional institution.

All other uses and disclosures of information about you will be made only with your written authorization. You may revoke your authorization at any time by notifying us in writing unless (a) we have already acted in reliance on your authorization, (b) the authorization was obtained as a condition of your obtaining insurance coverage, or (c) other laws provide your insurer with the right to contest a claim under your policy.
In addition, we may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In no circumstance will we sell or provide your information to an outside party for commercial purposes.
Please note that, even if you have agreed to receive this notice electronically, you have the right to obtain a paper copy of this notice upon request. For more information on our privacy policies, to submit a request for access to your records, or for any other need related to the management of your information at Todd S Gillingham MD, LLC, please contact:

Administrator & Privacy Officer
Todd S Gillingham MD, LLC
17200 NW Corridor Ct. Ste 110
Beaverton OR 97006
503-614-8633

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

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ACKNOWLEDGMENT AND CONSENT

I understand that **Todd Gillingham, MD, LLC,** (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 others 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 uses 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 Practices. 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.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

Patient has refused to sign this agreement: _____

Todd Gillingham, MD, LLC Staff Initials/Date

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Dear Valued Gillingham Family Practice Client:

To ensure the confidentiality of your information and to comply with current and pending Federal & State compliance & privacy regulations in the United States, Gillingham Family Practice is deploying a new Secure Messaging solution, called the Gillingham Family Practice Secure Email Network.

This message explains how to easily set up your complementary account on the Gillingham Family Practice Secure Email Network. Following the steps below will enable you to send and receive secure and confidential email messages regarding your account. You will never be charged for the usage of the Network. Please keep this notification for reference on accessing the Network in the future.

The Gillingham Family Practice Secure Email Network uses 2 levels of encryption technologies (256 –bit AES & 128-bit SSL) to make communication of electronic confidential information safe and secure.

Steps for registering your account on the Gillingham Family Practice Secure Email Network:

1. For ease of use, you will either receive a Secure Message, or an invitation from someone at GILLINGHAM FAMILY PRACTICE. Simply click on the link in the email to open up your Web Browser, and follow the instructions provided. We strongly encourage you to register your Free account using the link provided at the bottom of your secure message. If you receive and invitation, simply follow through the quick 20-second registration process to complete your profile, and create your own password. For security purposes, your password should be at least 8 characters in length and must include at least 1 number. If you wish to register your free guest account, and have NOT received an invitation, you can create your own profile and password within the GILLINGHAM FAMILY PRACTICE Secure Web Client.

Steps for logging into the Gillingham Family Practice Secure Email Network:

1. The next time you receive a new secure email message from Gillingham Family Practice; it will contain a direct link to access your secure message on the Gillingham Family Practice Secure Email Network. Simply click it to access the secure web client login page. Alternatively, visit our web login directly at https://protected trust.com/gillingham/
2. Enter the email address used to register with the Network, along with your password you picked. If you forgot your password, simply click on the 'Forgot Password?' link at the bottom of the login page.
3. Feel free to download any of the free client plug-ins available through the secure web client. Currently, we integrate with Outlook 2003/2007/2010, all popular Web Browsers, and most Mobile Web Browsers. Native iPhone, iPad and Android Apps will be available soon.

For any questions, please contact:support.gfp@nkrypt.com
For additional training, feel free to visit http://n-krypt.com/getting started.html

We take protecting the privacy of electronic confidential information with you seriously. The Gillingham Family Practice Secure Email Network is a result of continuous thorough evaluation of systems, policies and regulations to ensure the highest level of data security for client information. We value our relationship with you, observing the highest standards in email Privacy and Protection

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FINANCIAL POLICY

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read our financial policy in its entirety, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**: We participate in most insurance plans, including Medicare. It is the responsibility of the patient to confirm your coverage and our network participation with your plan as insurers add plans without notice that we may be excluded from.
    a. If you are not insured by a plan we do business with, payment in full is expected at each visit.
    b. If you are insured by a plan we do business with but don't have an up-to- date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
    c. **Proof of insurance** - All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of you claim(s).
    d. **Insurance coverage changes**: If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

2. **Claim submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party in that contract.
    a. If your insurance company denies payment your claim due to Coordination of Benefits (COB) or waiting on information from patient, the balance will automatically be billed to you upon notification of nonpayment by insurance. When you comply with the insurance plan's request for info, the balance will be transferred back to insurance upon receipt of their payment.

2. **Co-payments:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services:** Please be aware that some and perhaps all the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. Medicare patients will be given a Medicare Advanced Beneficiary Notice (ABN) of non-coverage spelling out what is not covered and the cost to you before any services are rendered.

4. **Patient balances**: For balances that are the patient's responsibility, we request that you keep a credit/debit card securely on file with us. This allows us to process payment for your financial liabilities in a quick and secure manner. We send patient statements out monthly. Prior to running statements, we process all the credit cards on file. Patients with credit cards on file will not receive a statement if their balance is zero. Your financial ledger is available for your review and download in our Patient Portal. Credit cards are stored securely in a banking system that masks all but a few numbers for easy selection. We do not keep any credit card information in our systems or physically in our office. We are fully Payment Card Industry (PCI) standards compliant. If you have questions about your balance, please contact our billing office 503-582-8283.

7. **Nonpayment**: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Financial hardship:** If you cannot afford your medical with this office, please notify the Receptionist who will provide you with our Financial Hardship application. We do offer charitable hardship services for those who qualify based on income.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

I have read and understand the payment policy and agree to abide by its guidelines:

_____	_____	_____
Signature of patient o responsible party	Relationship to Patient	Date