**Thank you for your interest in Rogue Pediatrics!**

**If you would like to establish your children as patients, please print and fully complete this inquiry packet and return all pages, except for this page and your copy of the privacy practices, to the address below:**

**Rogue Pediatrics**
**2940 Doctors Park Drive**
**Medford, OR 97504**

**You may also fax the completed packet to 541-779-9171.**

**If you do not have a printer, please call the office at 541-779-1300 and request a packet to be mailed or faxed to you.**

**The physicians review all received inquiries and will determine if they have the capacity to establish care at that time and, if able, how soon they feel the first visit should be. This review generally occurs within two weeks of receiving the packet. You will be contacted once a determination has been made. If you have not heard from us within three weeks of returning the completed packet, please call the office.**

**We strive to never close our practice to new patients, but also believe in not having more patients than we can provide exceptional care for. This unfortunately makes it necessary, on occasion, to decline potential new patients or to schedule their initial appointment several months in the future. We truly apologize if this ends up being necessary.**

**Thank you again for your interest and have a wonderful day!**

**PATIENT INFORMATION: (Please print)**

**Physician interested in establishing with at Rogue Pediatrics:**
**Christensen Young Either**

Name:_____ Birthdate:_____
Address:_____ City:_____
State:_____ Zip code:_____ Phone:_____

****If there are other children you are wishing to establish for whom all other information on this page applies, you may list their names and dates of birth below. If there are different parents or guardians, addresses, phone numbers, emergency contacts, or insurance information, please complete a separate sheet for each child with unique information.

Name:_____ Birthdate:_____
Name:_____ Birthdate:_____
Name:_____ Birthdate:_____
Name:_____ Birthdate:_____

**PARENT/LEGAL GUARDIAN INFORMATION:**

First parent name:_____ Birthdate:_____
Address (if different):_____City:_____ State:_____ Zip:_____
Phone:_____ Employer:_____Occupation:_____
Relationship to patient:_____

Second parent name:_____ Birthdate:_____
Address (if different):_____City:_____ State:_____ Zip:_____
Phone:_____ Employer:_____Occupation:_____
Relationship to patient:_____

**EMERGENCY CONTACT INFORMATION:**

Name:_____ Phone:_____ Relationship:_____

Primary Insurance Company:_____ Policy Number:_____
Secondary Insurance Company:_____ Policy Number:_____

Previous physician/office:_____ Reason for leaving:_____

How did you learn of us?: ☐ Internet ☐ Friend/Co-worker/Other - Name:_____

***Please list any current symptoms, concerns, or issues you are hoping to discuss with the physician at an upcoming appointment:**
_____
_____

**OFFICE USE ONLY**

**ABLE TO ESTABLISH AT THIS TIME?: Y / N _____**

**DURATION AND TIMING OF INITIAL APPOINTMENT:_____**

**NEW PATIENT HEALTH HISTORY**

**PATIENT NAME**:_____ **BIRTHDATE**:_____

**SOCIAL HEALTH HISTORY**

Who all lives at home?:_____

Parental relationship: ☐ Together ☐ Apart but good ☐ Apart with frequent conflict regarding parenting issues/custody/visitation

Daytime routine most of year: ☐ In childcare ☐ Home w/parent ☐ In school Grade:_____ School:_____

Substances used by household members: ☐ Smoked/Vaped tobacco ☐ Cannabis/Marijuana ☐ Alcohol ☐ Other_____

Approximately how many hours per week does your child spend:

On TV/Tablet/Phone:_____ Playing video games:_____ On a computer (non for homework):_____

Reading:_____ On homework:_____ Exercising/Playing actively:_____

**FAMILY HEALTH HISTORY** Have any biological parents/grandparents/siblings had any of the following conditions:

| | | | |
|---|---|---|---|
| Allergies or asthma | ☐No | ☐Yes | Who_____ |
| Anxiety/Depression/ADHD/Bipolar/Schizophrenia | ☐No | ☐Yes | Who_____ |
| Heart disease/high cholesterol | ☐No | ☐Yes | Who_____ |
| Diabetes/thyroid disease/obesity | ☐No | ☐Yes | Who_____ |
| Substance addiction problems | ☐No | ☐Yes | Who_____ |

Other/Additional info_____

**PATIENT HISTORY**

Birthplace: ☐ Hospital ☐ Home ☐ Other:_____ Birth Weight:_____ Length:_____

Delivery (check all that apply): ☐ vaginal ☐ cesarean ☐ before 37 weeks ☐ after 42 weeks

Complications with pregnancy/delivery?: ☐No ☐ Yes _____

**ILLNESSES/INJURIES:**

| | | | | | |
|---|---|---|---|---|---|
| Allergies/Hay Fever/Asthma | ☐No | ☐Yes | Constipation or frequent abdominal pain | ☐No | ☐Yes |
| Recurrent ear infections | ☐No | ☐Yes | Bladder or kidney infections | ☐No | ☐Yes |
| Poor bladder/bowel control | ☐No | ☐Yes | Hearing or vision problem | ☐No | ☐Yes |
| Anemia or bleeding disorder | ☐No | ☐Yes | Depression or anxiety | ☐No | ☐Yes |
| ADHD/ADD | ☐No | ☐Yes | Heart problems or murmur | ☐No | ☐Yes |
| Diabetes | ☐No | ☐Yes | Pneumonia | ☐No | ☐Yes |
| Bipolar or schizophrenia | ☐No | ☐Yes | Frequent headaches | ☐No | ☐Yes |
| Seizures | ☐No | ☐Yes | Eating disorder | ☐No | ☐Yes |
| Eczema/chronic rashes | ☐No | ☐Yes | Menstrual problems | ☐No | ☐Yes |
| Thyroid disorder | ☐No | ☐Yes | Fainting/dizziness | ☐No | ☐Yes |

Other:_____

Hospitalizations/Surgeries:_____

Medications:_____ Drug allergies:_____

Is your child up to date on all immunizations required by the state for school/daycare attendance? ☐ Yes ☐ No

Have you ever requested or signed a waiver opting out of one or more vaccines at a school or daycare? ☐ Yes ☐ No

If not up to date, why not? ☐ Missed some but will catch up ASAP ☐ Only do some vaccines ☐ Do not vaccinate

Which vaccine(s) have you chosen not to receive?:_____

Please check any of the following clinicians used by the patient or immediate family members:

☐ Dentist ☐ Physical Therapist/Occupational Therapist ☐ Chiropractor ☐ Naturopath

☐ Speech therapist ☐ Psychiatrist/Psychologist/Counselor ☐ Specialist (e.g. Cardiologist)_____

Name of person completing form:_____

Signature:_____ Date:_____

**Rogue Pediatrics Office and Financial Policies/Authorization to Treat**

- Advice can only be given for the patient scheduled for the appointment. For other patients, please schedule an appointment separately.
- We are unable to accommodate walk in patients and see patients by appointment only.
- Appointments should be cancelled 24 hours in advance. Excessive no-shows or late cancellations may result in dismissal or $20.00 fee.
- Patients arriving 10 or more minutes late for their appointment may be rescheduled to the future.
- Additional concerns brought up during the visit not mentioned when scheduling may require a future visit.
- For OHP patients, we will attempt to verify OHP coverage for the visit date. If unable to, payment in full may be required in advance.
- A $25 fee may be charged for completion of FMLA paperwork and other forms
- Please call your pharmacy for refill requests other than ADHD meds/controlled substances and allow 2 business days for completion.
- A parent or legal guardian must accompany the child to all new patient visits, well-visits and evaluations of chronic or ongoing issues. An exception may be made for a stepparent/grandparent that resides in the home at the discretion of the physician if requested in advance.
- Copays/patient responsibility portions are due at the time of service unless arrangements are made in advance.
- It is the **responsibility of the patient/legally responsible adult** to know your benefits, coverage, and patient responsibility. We will submit insurance claims, but you are responsible for our charges. ***We will NOT call to verify insurance coverage or benefits***
- We may bill your secondary carrier as a courtesy. You are still responsible for any balance remaining.
- Private pay patients are expected to pay at the time of service unless other arrangements are made in advance.
- This office is NOT a party to your divorce decree. The financial responsibility for minors rests with the **accompanying** adult.
- Until changed in writing, fiscal responsibility remains with the parent/guardian signing below even after the patient is 18 years of age.
- We may apply a finance charge of 1.5%/month (18% annually) to balances over 90 days as allowed by law. A fee of $25.00 will be charged for any check returned due to non-sufficient funds. We accept cash, personal checks, and most credit cards.
- When making any referrals for testing or to another physician or facility, you have the choice of your preferred location.
- **Well visits are for PREVENTIVE CARE and fall under PREVENTIVE CARE BENEFITS which usually involve no cost sharing on your part. BRINGING UP CURRENT SYMPTOMS/PROBLEMS AT YOUR PREVENTIVE CARE VISIT WILL REQUIRE WE BILL SEPARATELY FOR THOSE SERVICES IF THE PHYSICIAN ADDRESSES THEM. Providing evaluation and management services while billing for preventive services is insurance fraud and we cannot participate in such.**
- Other caregivers may bring the child in for minor acute issues, and receive information about those issues only, if permission is given in advance. You still have financial responsibility for all office visits. Please list authorized individuals below. You may change or revoke on request. We will not discuss any other aspect of care, past care, or future care with these individuals.

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Siblings also seen at Rogue Pediatrics and DOB: _____ _____ _____

_____ _____ _____ _____

I accept the terms of Rogue Pediatrics office policies and authorize treatment of the patient listed above as deemed necessary by the physician. I authorize Rogue Pediatrics to release information to my insurance company or another physician/health practitioner/entity for the purpose of follow up or medical treatment. I authorize Rogue Pediatrics to release immunization records to schools when requested by the school. I assign all payments directly to Rogue Pediatrics for services performed. I understand I am responsible for all charges. Should it be necessary to collect monies in court, all court costs and attorney fees are my responsibility.

_____(initial) I have received a copy of Rogue Pediatrics Notice of Privacy Practices (included with new patient packet).

_____(initial) I agree to leaving a detailed message when needed and unable to reach me.

Patient Name_____ Parent Signature_____Date_____

# ROGUE PEDIATRICS NOTICE OF PRIVACY PRACTICES EFFECTIVE DATE: 4/1/22

**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.**

If you have any questions about this notice, please contact the office manager at (541)779-1300
All requests must be made in writing to the Privacy Officer at 2940 Doctors Park Drive Medford, OR 97504

**We may use and disclose your health information (PHI) for the following purposes**:

- In the course of providing treatment such as faxing chart notes and test results to a specialist to whom we are referring you.
- For payment purposes such as sending your diagnosis codes to your insurance carrier to bill for a visit.
- For health care operations such as a facility directory or educating staff about your diagnosis to help care for you in the future.
- To avert a serious threat to the health or safety of yourself or another person, when required by law or law enforcement including court order or subpoena, to facilitate organ donation if you are a donor, and if de-identified.
- To "Business Associates" who provide services to our clinic and for research projects subject to special approval. We will ask permission before revealing personally identifiable information to a researcher or involving a researcher in your care.
- For workers compensation/similar programs, for public health reasons such as statutory reporting, for health oversight activities such as audits and inspections, and to coroners, medical examiners and funeral directors after death.
- For members of domestic or foreign armed services if required to do so by government authorities.
- To family members or friends (including personal representatives) if we obtain your verbal agreement or if we give you an opportunity to object and you do not. We may also disclose your PHI to your family or friends if we infer, based on our professional judgment that you would not object. In situations where you are not capable of consenting such as absence or incapacity we may, using our professional judgment, determine that a disclosure to a family member or friend is in your best interest but will disclose only PHI relevant to the person's involvement in your care. We may also use our judgment to infer that it is in your best interest to allow another person to act on your behalf to pick up prescriptions, supplies etc.
- We may disclose your PHI to disaster relief organizations that seek it to coordinate your care or notify family/friends of your location/condition in a disaster but will provide you with an opportunity to object to this whenever we can practically do so.

We do not maintain electronic PHI and are not mandated to disclose PHI kept in paper form to a third party. If a third party is requesting PHI from you, expect to be required to obtain a copy directly from our office personally via your individual right of access and to provide a copy of the PHI to the third party yourself. Repeated access requests for the same PHI are subject to denial so preserve the original copy provided indefinitely. In the rare instance in which we agree to disclose your PHI to a third party for any purpose other than those above, your written authorization will be required which you may request to revoke at any time. If revoked, we will no longer disclose PHI for the reasons covered by the authorization but cannot reverse previous disclosures. We will need written authorization from you to disclose PHI for marketing purposes, sell PHI, or to disclose certain types of specially-protected PHI such as HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

**Your rights**:

- You have the right to request to inspect, copy, or obtain a summary of your PHI. We may charge a reasonable fee for copies. We may deny your request and if so, you may request a review of the denial. If legally allowed, we will choose a licensed health care professional not involved in the denial to review it and abide by their decision.
- You have the right request that we amend your PHI possessed by us if you believe it is incorrect or incomplete. Your request may be denied if it does not include supporting information, the person creating the PHI is no longer here to amend it, we did not create the PHI, or the PHI is accurate and complete. If we deny your request, you have the right to submit a rebuttal and request it be made a part of your record. Your rebuttal needs to be less than two pages in length. We may rebut your rebuttal in the medical record. You have the right to request that all documents associated with the amendment request be transmitted to any other party when that portion of the medical record is disclosed.
- You have the right to request an "accounting of disclosures" of your PHI for no longer than 6 previous years for purposes other than treatment, payment, health care operations, or when specifically authorized by you plus some circumstances involving national security, correctional institutions and law enforcement. One list per 12 months is free.
- You have the right to request a restriction/limitation on the PHI we use/disclose about you for treatment, payment or health care operations, facility directories and to someone involved in your care or the payment for it, like a family member/friend. We are not required to agree to this except for PHI disclosure to your health insurer if all services/supplies were paid "out of pocket".
- You have the right to request that we communicate with you about PHI in a certain way or at a certain location such as only by mail or via your home phone number. We will do our best to accommodate reasonable requests.
- You have the right to a paper copy of this notice upon verbal request while in the office or written request by mail.

We are required to maintain the privacy of your PHI, provide you with a notice of legal duties and privacy practices with respect to PHI, notify affected individuals affected by a breach of unsecured PHI and abide by the terms of this notice. We reserve the right to make changes to our privacy policy and update this Notice accordingly making the revised Notice effective for any current PHI and any future PHI we possess. If you believe your privacy rights have been violated, you may file a complaint with our office by contacting the Privacy Officer at (541)779-1300 or with the Secretary of HHS. You will not be retaliated against for filing a complaint.