McKenzie Medical Group

Cardiology – Cardiothoracic Surgery - Gastroenterology - General Surgery
Infectious Disease – Obstetrics & Gynecology - Vascular Surgery

Welcome to McKenzie Medical Group!
We are looking forward to your visit.

Appointment Confirmation

We have scheduled your consultation on _____ at _____ AM ◯ PM ◯

with _____. Please check in at _____ AM ◯ PM ◯

Clinical specialists united in one purpose – caring for your healthcare needs

Cardiology - Springfield
960 16th St., Suite 100 & 304
Springfield, OR 97477
P: 541-744-6172

Cardiology – Eugene
1835 Pearl St.
Eugene, OR 97401
P: 541-744-6172

Cardiothoracic Surgery
960 16th St., Suite 100
Springfield, OR 97477
P: 541-744-6916

Gastroenterology
960 16th St., Suite 200
Springfield, OR 97477
P: 541-726-4409

General Surgery
960 16th St., Suite 200
Springfield, OR 97477
P: 541-345-2205

Infectious Disease
960 16th St., Suite 108
Springfield, OR 97477
P: 541-741-4646

Obstetrics & Gynecology
1460 G St., Ste 100
Springfield, OR 97477
P: 541-345-2205

Vascular Surgery
960 16th St., Suite 104
Springfield, OR 97477
P: 541-988-3660

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Helpful Information About Your Upcoming Appointment

- **Clinic Location:**
  We have multiple clinic locations. *Please double-check that you are going to the correct location for your scheduled appointment.*
- **Arrival Time:**
  Please arrive **20 minutes early** to allow time for:
  - Check-in
  - Completing paperwork
  - Reviewing medications
  - Taking vital signs prior to seeing your provider
- **What to Bring:**
  - Government-issued photo ID
  - Insurance card(s) *(we will need to make a copy at each visit)*
  - Current medication list **or** medication bottles
  - Completed health history forms
- **Payments:**
  Please be prepared to pay any co-payments, deductibles, or deposits at check-in.
- **Visit Details:**
  This first visit is typically a consultation only. Unless instructed otherwise, you may eat and drink beforehand.
- **Cancellations:**
  Please notify us at least **48 hours in advance** if you are unable to attend your appointment.
  - Three missed appointments or late cancellations (less than 48 hours notice) may result in your dismissal from the practice.
- **Late Arrivals:**
  Arriving **15 minutes late** may require your appointment to be rescheduled.

Please contact us if you have any questions or concerns. We are here to serve your healthcare needs.

Acknowledgment

By signing below, you acknowledge that you understand the check-in requirements and short-notice cancellation policies.

Signature: _____ Date: _____

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Patient Information

Name: _____ Date of Birth: _____ Sex: M ◯ F ◯

Guarantor: _____ Relationship to Patient: _____

Social Security Number: _____ Email: _____

Marital Status (Check One): Married ☐ Single ☐ Divorced ☐ Widow ☐ Partner ☐ Other ☐

Race: _____ Ethnicity: _____ Primary Language: _____

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

Home Phone: (___) _____ Cell: (__) _____ Work: (__) _____

Okay to leave medical information on home voicemail? Yes ◯ No ◯

Okay to leave medical information on cell voicemail? Yes ◯ No ◯

Okay to leave medical information on work voicemail? Yes ◯ No ◯

Preferred Pharmacy: _____ Location: _____

Primary Insurance: _____ Secondary Insurance: _____

Primary Care Physician: _____

Release of Information Consent

I authorize McKenzie Physician Services to discuss **ANY** information regarding my care with the below mentioned persons:

Name: _____ Relationship: _____

Primary Contact Number: _____ Secondary Contact Number: _____

Name: _____ Relationship: _____

Primary Contact Number: _____ Secondary Contact Number: _____

Do you have an Advanced Directive? Yes ◯ No ◯

Do you have a Power of Attorney? Yes ◯ No ◯

By signing below I am acknowledging the above information to be accurate. I undertand that in order to revoke my consent to share my medical information with the above individuals, I need to do so in writing.

Name: (Please Print): _____ Date: _____

Signature: _____

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1. ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:

   I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third- party, or proceeds of all claims resulting from the liability of a third-party, payable by any party, organization et cetera, to or for the patient unless the account for this Facility or series of outpatient visits are paid in full at the time of discharge or at the end of the series of outpatient visits. If eligible for Medicare, I request Medicare services and benefits, I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for any charges not covered by my insurance company.

   I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the facility. If I fail to make payment when due and the account becomes delinquent or is turned over toa collection agency or an attorney for collection. I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent for the facility to appeal on my behalf any denial for reimbursement, coverage, or payment for services or care provided to me.

2. PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):

   I have been made aware and understand that the medical practice and offices may use electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic system will be able to see information about medications I am already taking, including those prescribed by other providers. I give consent to my providers to see this protected health information.

   I have been provided the Electronic Prescribing Notice Included in the Note of Privacy Practices.

3. NOTICE OF PRIVACY PRACTICES:

   Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Facility's Notice of Privacy Practice. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Facility, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing and other types of treatment received.

4. GENERAL CONSENT FOR TEST, TREATMENT, AND SERVICES:

   I agree and understand that all physicians (including fellows, residents, physician assistants, nurse practitioners, and interns) involved in my case in any way are responsible and liable for their own acts and omissions, and the facility/practice is not responsible or liable for the acts or omissions of the aforementioned. Services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

   I have been informed of the treatment considered necessary for me that the treatments/procedures will be directed by a physician and may be performed by such a physician and/or one or more physicians, fellows, residents, interns, and employees of the Facility. I understand that one or more of the physicians, fellows, residents, and/or interns at the Facility may treat me or participate in my treatment.

   I understand that no guarantee or assurance has been made regarding (1) which physician and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

5. CONSENT TO PHOTO/ VIDEO:

   I consent to the photographing or videotaping, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released with protected health information regulations

   _____ (patient initials)

6. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION:

   ◯ Yes ◯ No I, nor my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's ambulatory medical record electronically as my photo identification.

7. EMAIL:

   ◯ Yes ◯ No I hereby consent to provide my e-mail address so that representatives from the Facility can e-mail information to me about health education or disease prevention and up to date information about the Facility, its affiliated physicians, and our services. I understand I will be able to change my preference at any time.

8. IMAGING SERVICES:

☐ Please check this box to allow the facility's imaging services to share your images with affiliated facilities. When requested for continuing medical treatment.

9. CELL PHONES:

◯ Yes ◯ No I hereby consent to provide my telephone number(s), including my wireless telephone number(s), so that representatives from the Facility, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice by texting or by emailing regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, schedule, billing, or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I ill be able to change my preferences at any time.

Patient's Signature or Legal Representative		Date	Time
Relationship to Patient	Interpreter, if Utilized	Date	Time
Witness Signature	If telephone consent, Second Witness signature	Date	Time

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Release of Information

Request From Other Agency

All portions of this form must be completed to constitute a valid authorization for release of information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

Patient Name: _____ Date of birth: ____/____/_____

Address: _____City_____State:_____ Zip: _____ Phone:_____

I authorize: Agency or Individual authorized to release my health information: _____

Agency phone: _____ **Agency fax:** _____

To: McKenzie Medical Group 960 16th Street – Springfield, Oregon 97477

Health information that may be used / disclosed is limited to the following: ☐ Progress notes ☐ Emergency Room Record
☐ Discharge Summary ☐ History & Physical ☐ Consultations ☐ Lab ☐ Pathology Report ☐ Operative Report
☐ Imaging/X-Ray (images) ☐ X-Ray Reports ☐ Entire Record
☐ Other (Specify): _____

Health Information that may be used / disclosed is limited to the following periods of healthcare:
From (date): _____ To (date): _____
From (date): _____ To (date): _____

Health Information to be released to the above-named agency / individual is to be used / disclosed for the following purposes(s):
☐ At request of patient ☐ Treatment / Consultation ☐ Research ☐ Marketing ☐ Billing or claims payment
☐ At request of employer ☐ Other: _____

"Health information" identifies you (the patient) by name and includes other demographic information about you. "Health information" may include, but is not limited to: Medical records, Imaging films, slides, CD/DVD, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol abuse, drug abuse, communicable diseases including HIV status and / or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

☐ Yes ☐ No If applicable, I agree to the release of my medical or billing records containing the sensitive information above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If search-related Health Information is used or disclosed for continued research purposes, and expiration date or event does not apply.

This authorization will automatically expire 60 days after the date of signature (except as indicated above) unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPPA prohibits such condition. If condition is permitted, refusal to sign the authorization may result in denial of care or coverage.

Notice to receiving agency or individual: This information is to be treated in accordance with HIPPA privacy regulations.

_____ _____/____/_____ _____
Patient's or Authorized Personal Representative's Signature *Date of signature* *Time*

_____ _____
Relationship to Patient / Authority to Act on Patient's Behalf *Interpreter, If Utilized*

_____ _____/____/_____ _____ _____
Staff Witnesses Signature *Date of signature* *Time* *Expiration date or Event*

☐ ***Signature validated against driver's license or signature in Medical Record**