LANE COUNTY BEHAVIORAL HEALTH
&
COMMUNITY HEALTH CENTERS OF LANE COUNTY

New Patient Registration Form

Please complete entire form

Patient Information:

Last Name	**First Name**	**Middle Name**	**Nickname** (Preferred Name)

Birth Date: _____ /_____ /_________ (Month/Day/Year)

Birth Sex: ☐ Male ☐ Female

Gender Identity:	**Sexual Orientation:**	**Preferred Pronoun:**
☐ Female	☐ Straight	☐ He, Him, His
☐ Male	☐ Bisexual	☐ She, Her, Hers
☐ Transgender Male (FTM)	☐ Lesbian or Gay	☐ They, Them, Theirs
☐ Transgender Female (MTF)	☐ Something else	☐ Ze, Hir
☐ Other	☐ Choose not to disclose	☐ Other
☐ Choose not to disclose	☐ Don't Know	☐ Decline to Answer

Patient Address Information:

Residential Address			Mailing Address ☐ Same as Residential		
City	State	Zip	City	State	Zip

Patient Contact Information:

Patient Primary Phone (where appointment reminders* will go):
(   )
Type: ☐ Home ☐ Day ☐ Cell

Patient Other Phone:
(   )
Type: ☐ Home ☐ Day ☐ Cell ☐ Alternate ☐ Secondary

*Appointment Reminder Preference (notifications): ☐ Text ☐ Voice

Emergency Contact Information:

Emergency Contact Name:	Relationship to Patient:	Emergency Contact Phone: ( )

For Pediatric Patients – Parental Information:

☐ Father ☐ Mother Name:	☐ Father ☐ Mother Name:
Primary Phone: ( )	Primary Phone: ( )

For Patient with Guardian – Guardianship Information: *(guardianship documentation required)*

Legal Guardian's Name:	Legal Guardian's Primary Phone: ( )

Additional Patient Information:

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other_____________________________

Do you need an Interpreter at appointments?: ☐ No ☐ Yes, please specify language ______________________________

Housing Situation – *Check the item that best describes your household:*	**Race –** *Please check ALL items that best describe your race:*	**Ethnicity** – *Check the item that best describes your ethnicity:*
☐ Doubling up (couch surfing)	☐ Alaskan Native/American Indian	☐ Hispanic or Latino
☐ Homeless shelter	☐ Asian	☐ Not Hispanic or Latino
☐ Not Homeless	☐ Black/African American	
☐ Not homeless, was in last 12 months	☐ Native Hawaiian	
☐ Other	☐ Pacific Islander	
☐ Street, Camp, Bridge (Homeless/Transient)	☐ White	
☐ Transitional housing (halfway house)		

Additional Patient Information Continued

Veteran Status: ☐ Veteran ☐ Not a Veteran

Worker Status:

Is your family's main source of income from a job as an agricultural laborer or farm worker? • Includes planting, weeding, thinning, irrigation, and/or harvesting of crops and/or trees	☐ Yes	☐ No (neither)
If yes, *Did* you or your family move in the last two years in order to perform this work? • Includes those who have stopped moving due to disability or age	☐ Moved (migrant)	☐ Didn't Move
If yes to first question, *Do* you or your family work in agriculture all year long or only seasonally?	☐ All Year	☐ Seasonally (seasonal)

Income and Household Data

Household Monthly Gross Income: $ __________	Family Size (# of people supported by household income): _________

Financial Responsibility Information

Responsible Party: Person responsible for this account (even if you have insurance):

SELF (circle if you are responsible for this account); If not, complete below:

Last Name	First Name	Relationship to patient	Gender ☐ Male ☐ Female
Address	City	State Zip	Date of Birth

Insurance information – PLEASE HAVE CURRENT INSURANCE CARDS AVAILABLE AT EACH APPOINTMENT

☐ I have Oregon Health Plan	☐ I have private insurance	☐ I do not have health insurance	**Attach Copies of Insurance Card(s):**

Primary Insurance Company Information		Secondary Insurance Company Information	
Primary Insurance Company	Effective Date	Secondary Insurance Company	Effective Date
Group Number	ID #/Policy #	Group Number	ID #/Policy #
Insured Party		Insured Party	
Relationship to patient		Relationship to patient	
Date of Birth	Phone #	Date of Birth	Phone #

Assignment of Benefits/Insurance Release

I hereby authorize Lane County Health & Human Services to bill my insurance company directly for all services provided for medical and/or mental health treatment. I understand I am financially responsible to Lane County Health & Human Services for charges not covered by my insurance benefits and that I am directly responsible for payment of all charges within the limits of Lane County Health & Human Services credit policy regardless of insurance coverage. I hereby authorize Lane County Health & Human Services to furnish to my Insurance Company(s) all information which said Insurance Company(s) may request and/or require concerning my illness(es) and/or injury(s) including all psychiatric, drug, alcohol abuse, acquired immunodeficiency syndrome, thus releasing Lane County Health & Human Services from any liability for furnishing such information.

_______________________________ _________________________________ _____________

Patient Signature **Parent or Legal Guardian Signature** **Date**

Print Name/Relationship to Patient:____

*In the event a legal representative other than parents of minor child signs this Authorization, documentation of legal authority must be attached (i.e. Health Care Power of Attorney or court appointed Health Care Representative.)

Continued on next page

Consent To Treat

I hereby authorize the providers of Lane County Health & Human Services to provide such health services, including medical, mental health, surgery, regular or emergency services, as determined to be in the best interest of myself, my child or legal charge, if I am a parent or legal guardian.

I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits, and alternatives to each service proposed for my services. I understand that my participation in services is voluntary, I have the right to refuse any particular service, and I may withdraw from all services at any time. I understand that I have the right to ask questions about any service provided at any time. If I have concerns, I have the right to talk to a Program Supervisor and/or file a complaint or grievance which will be responded to promptly and respectfully

I understand that there are several exceptions to the Individual/Provider privilege. For example, Under Oregon Law, Lane County Health & Human Services must report:

a. child abuse
b. elder abuse
c. abuse of mentally ill persons or developmentally disabled persons
d. when required by a court order
e. harm or potential harm to self or others

This authorization shall continue and be in full force and effect until revoked in writing.

______________________________	______________________________	____________
Patient Signature	**Parent or Legal Guardian Signature**	**Date**

Print Name/Relationship to Patient:____

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Patient Label

Well Child Check Questionnaire for Children: 11-17 Years of age

Previous Primary Care Provider and location : ____________________

Who lives in the home with the patient (names/ages):____________________

PAST MEDICAL HISTORY (please mark box if yes): ☐ Check box if none ☐ Unknown				
☐ Asthma	☐ Eczema	☐ Birth defects	☐ Cancer	☐ Scoliosis/Joint prob
☐ Seasonal allergies	☐ Heart condition	☐ Thyroid problems	☐ Diabetes	☐ Vision/ Eye prob
☐ Heartburn	☐ Seizures	☐ Sleep apnea	☐ Drug use	☐ Hearing/ Ear prob
☐ ADD/ ADHD	☐ Learning disability	☐ Depression	☐ Anxiety	☐ Sleep problems
☐ Concussion Date:		☐ Loss of consciousness Date:		
☐ History of injury		Date and type:		
☐ History of fractured / broken any bones		Date and bone:		
☐ Historyof hospitalized (other than at birth)		Date and reason:		
☐ History of blood transfusion		Date and reason:		
Concerns / Explain: ☐ Check box if none				

SURGICAL HISTORY: ☐ Check box if none ☐ Unknown

Surgery	**Year**	**Surgery**	**Year**
Appendix:		Tympanostomy (ear) tubes:	
Other:			

FAMILY HISTORY: ☐ None ☐ Unknown ☐ Adopted

Disease	**History**	**Relationship (father, mother, brother, sister)**
Bleeding Problems/ Clotting Disorder	Y / N	
Cancer (type):	Y / N	
Heart Disease(type):	Y / N	
High Blood Pressure	Y / N	
Diabetes (type):	Y / N	
Asthma	Y / N	
Immune Disorders (type):	Y / N	

HOME ENVIROMENT / SAFTEY:

Y / N	Does your child wear a seat belt?	Y / N	Does your child wear a helmet?
Y / N	Do you feel safe at home?	Y / N	Does anyone smoke at home?

EDUCATION:			
School Name and location:			
Grade in School:	Y / N	Has your child repeated any grades? List:	
Grades Earned:	Reason for repeating grade(s):		
Concerns regarding school (absences, learning difficulties, problem behaviors)			

SLEEP/ Activity:	
Concerns about sleep (nightmares, napping, less than 8.5 hrs, problems falling /staying asleep)	
	Exercise / Play sports (hours per day)
	Screen time (TV/computer/games/phone

TUBERCULOSIS:	
Was your child born/traveled outside the US?	Has a family member had tuberculosis or positive TB skin test?

NUTRITION:	
Do you have nutrition concerns	

DENTAL CARE:			
Dental Concerns		Last Dental Appointment	

VISION AND HEARING:	
Y / N	Does this sound like your child? • Has difficulty seeing the blackboard • Has ever failed a vision screening • Holds books close to face/eyes • Has trouble recognizing faces at a distance • Tends to squint
Y / N	Does this sound like your child? • Has problems hearing over the telephone • Has trouble following the conversation with two or more people • Has trouble hearing with a noisy background • Asks people to repeat themselves • Misunderstands what people are saying and responds inappropriately

Lane County Behavioral Health
&
Community Health Centers of Lane County

Notice of Privacy Practices Acknowledgement of Receipt

The Notice of Privacy Practices tells you how Lane County HHS may use or disclose your information. Not all situations will be described. Lane County HHS is required to inform you of our privacy practices for the information we collect and keep about you.

I, ________________________________ (client's name), have been offered a copy of Lane County Health & Human Services' Notice of Privacy Practices. I have had a chance to ask questions about how my information will be used.

Relationship:

- ❑ Patient
- ❑ Patient's Guardian (or parent of un-emancipated minor patient)
- ❑ Person authorized to make decisions on behalf of patient (e.g. by a medical power of attorney)

____ Date:________________
Patient Signature

____ Date:________________
Parent or Legal Guardian Signature

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PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

- Be treated with dignity and respect.
- Be informed of rights as a consumer.
- Be treated equitably by providers regardless of insurance coverage.
- Be actively involved in the development of their treatment plan and be given information about their condition and the covered and/or non-covered services available to permit them to reach an informed decision about their treatment.
- Have written materials explained in a manner that is understandable.
- Consent to treatment or to refuse treatment and to be informed of the consequences of that decision.
- Receive a referral to specialty practitioners for medically appropriate services.
- Have a clinical record maintained that documents conditions, services received and referrals made.
- Receive an assessment of fees according to a sliding fee scale based on household size and income and to be provided with a copy of the fee assessment document.
- Confidentiality of all information and records, except as provided by state law, court order or by written permission to release information.
- Access to personal treatment records in accordance with State and Federal law.
- Receive written information and explanation regarding grievance procedures upon initiating treatment and on request thereafter.
- Assert grievances with respect to infringement of the rights described in this document, including the right to have such grievances considered in a fair, timely, impartial grievance procedure.
- Request a change of clinical worker, nurse practitioner or psychiatrist at any time during your treatment. Complete a Declaration of Mental Health treatment as a guide to future treatment options. Exercise all rights described in this document without any form of reprisal or punishment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. (CFR 438.100).
- Receive interpretation services, if needed.
- Transfer a copy of their clinical record to another healthcare provider.

Patients have the responsibility to:

- Respect the physical and emotional safety of other consumers.
- Communicate the effectiveness or ineffectiveness of treatment to their providers, so that optimal care can be determined.
- Participate in initial and ongoing treatment planning.
- Call in a timely manner to cancel appointments.
- Pay for services not covered by insurance, under the Clinic's sliding scale policy.
- Inform any Clinic staff of any address and/or phone number changes.
- Ask questions about conditions, treatments and other issues related to your care that you do not understand.
- Follow prescribed agreed-upon treatment plans.
- Treat all Clinic providers and staff with respect.

Clinic Locations

Brookside Clinic
1680 Chambers St., Eugene

Charnelton Community Clinic
151 West 7th Ave, Eugene

Delta Oaks Clinic
1022 Green Acres Road, Eugene

Lane County Behavioral Health-Primary Care
2411 Martin Luther King Blvd., Eugene

RiverStone Clinic
2073 Olympic St., Springfield

Springfield Schools Health Center
1050 10th St., Springfield