Pacific Women's Center
Physicians and Surgeons

Financial Policy

We offer the following explanations of the policies related to fees and costs. If you have questions regarding your account or need to set up a financial arrangement, please contact our billing representative.

Our fees: are determined by the individual care given. Health insurance may not cover the entire cost of your care. Medical care costs are rapidly rising, and we make every effort to keep costs down. Payment at the time of services can help reduce these costs. Co-pays and non-covered services are required to be paid at the time of service. We accept personal checks, Visa, MasterCard and Debit. We will bill your insurance as a courtesy to you, and we encourage our patients to contact their insurance carrier to determine what is covered by their plan. Remember that your account is your responsibility even though you have insurance.

Appointment Deposit Expectations for our New Patients: Required on your first visit, is a New Patient Deposit of $100 or your copay requirement for non-preventive care. For uninsured patients, a New Patient Deposit of $200.00 is required.

Should you require surgery, we will contact your insurance company to obtain pre-authorization prior to scheduling your surgery. Obtaining pre-authorization does not mean that your surgery will be covered at 100%. Prior to your pre-operative appointment, you will need to discuss your insurance benefits with the billing representative. You will be expected to pay the anticipated costs, including any applicable co-pays, co-insurances and/or deductibles prior to your surgery.

Referral Policy: It is the patient's responsibility to ensure that a valid referral is on file for your visit. Please be courteous to your Primary Care Physicians (PCP) and request the referral early, as some of the offices require 3 to 7 days of advance notice. If we do not receive a valid referral prior to your appointment, you may choose to sign a waiver and assume 100% of the cost or reschedule your appointment as most carriers will no longer allow retroactive referrals.

Understanding Your Office Visit: An annual exam (preventive, routine, wellness and well woman) includes an age-appropriate history & physical exam, risk factor review, ordering of routine laboratory tests, along with general discussion about healthy lifestyle and preventive care. Lab tests ordered as part of an annual exam are billed as preventive care services. All laboratory tests are billed for disease prevention, not to monitor a diagnosed disease. Generally, lab tests are a covered benefit under your plan but NOT paid at 100% and are frequently subject to plan deductible and copay requirements. You will be billed for any related balances due for the lab services directly from the laboratory providing the diagnostic analysis. A problem-oriented visit (menopause, depression, bleeding, etc.) addresses specific problems. How your office visit is billed (annual or problem) is determined by what happens during your visit, typically where the most focus is directed. However, it is possible that your visit may include both annual and problem services, which will be billed accordingly. Our billing office at 541-787-4729, M-F 7:30-4:00.

Statements: are posted to your patient portal and/or mailed monthly for any balance due on your account. Payment is expected upon receipt of the bill. We encourage you to review all statements for accuracy of services provided. Patient due balances over 60 days may be subject to interest and an additional billing fee of $10.00 per month.

No Show/Late Arrival Policy: If it is necessary for you to reschedule your appointment, please inform us immediately. If you are unable to keep your scheduled appointment, please cancel at least 24 hours prior to your scheduled appointment or a $100 fee may be incurred. Any two appointments missed without 24-hour notice may result in dismissal from our practice. If the clinic is closed, please leave a voice message at 541-342-8616.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care it is very important for each scheduled patient to attend their visit on time. Please plan on arriving 30 minutes prior to your scheduled appointment time. If you arrive late, you may be asked to reschedule your appointment in order to accommodate patients that have arrived on time.

Patient Signature: _____ **Date:** _____

Patient Name (Please Print): _____

Medical Practice
Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I am aware of the Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of Pacific Women's Center's health care operations. The Notice of Privacy Practices also describes my rights and Pacific Women's Center's health care operations. The Notice also describes my rights and Pacific Women's Center's duties with respect to my protected health information. **The Notice of Privacy Practice is posted in the front lobby and on Pacific Women's Center's website at *http://www.pacificwomenscenter.com/*.**

I further certify that I am aware of the Electronic Data Sharing provision which I have been given the option to Opt Out of and understand that by signing this acknowledgement I am agreeing to Pacific Women's Center LLC's participation to share my medical records with Facilities and Providers that will mutually participate in my healthcare.

Pacific Women's Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by mail, asking for one at the time of my next appointment, or accessing Pacific Women's Center's website.

_____ _____
Signature of Patient DOB

_____ _____
Print Patient Name Date

Or

_____ _____
Signature of Personal Representative Description of Personal Representative's Authority

_____ _____
Print Representative's Name Date

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In order to comply with the National Health Care Mandates, Pacific Women's Center is required *to collect the following information. It is intended to be a major step in enhancing the ability to monitor health care processes and outcomes for different population groups, target quality initiatives more efficiently and effectively, and provide patient-centered care.*

Name (Please Print): _____ DOB: _____

RACE (select all that apply)			
◯ American Indian or Alaska Native	◯ Asian	◯ Black/African American	
◯ Pacific Islander	◯ White/Caucasian	◯ Decline to Specify	
ETHNICITY (choose only one)			
◯ Hispanic or Latin	◯ Non-Hispanic or Latin	◯ Decline to Specify	
PREFERRED LANGUAGE (choose only one)			
◯ Arabic	◯ Asian Indian	◯ Chinese	◯ English
◯ Japanese	◯ Korean	◯ Spanish	◯ Other _____
LANGUAGE SPOKEN IN YOUR HOME (choose only one)			
◯ Arabic	◯ Asian Indian	◯ Chinese	◯ English
◯ Japanese	◯ Korean	◯ Spanish	◯ Other _____

◯ **I am requesting the services of an interpreter**
◯ **I am not requesting the services of an interpreter.**
◯ **I will bring a friend of family member to interpret for me.**

Referred By: ◯ **Doctor** ◯ **Family** ◯ **Friend** ◯ **Insurance** ◯ **Internet** ◯ **Other**

Pharmacy & Location: _____

Patient/Guardian Signature: _____ **Date:** _____

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PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

Address:_____ City, State, Zip: _____

Mailing Address (if different): _____ City, State, Zip: _____

Primary Care Physician (PCP): _____ SSN: _____ DOB: _____ Age: _____

Employer: _____ Work Phone: (_____)_____ Pref Pharmacy_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Preferred Phone: HOME / CELL

Can we leave *detailed* message on your voicemail? **HOME:** Y / N **CELL:** Y / N

EMAIL*: _____ Marital Status: M / S / D / W

**Normal lab results, notification and patient education will be reported and sent via the Patient Portal and a notification will be sent to your email listing. The Patient Portal provides patients with secured access to our office and their medical records.*

APPOINTMENT REMINDER: (choose only one) ◯ text ◯ voicemail

RESPONSIBLE PARTY INFORMATION

_____

Person Responsible for Bill Address Phone Number

PRIMARY INSURANCE

_____
Insurance Company Policy Holder

_____
Relationship to Patient DOB SSN

_____
ID/Subscriber Number Group Number

_____
Insurance Claims Mailing Address

_____
Insurance Phone Effective Date

SECONDARY INSURANCE

_____
Insurance Company Policy Holder

_____
Relationship to Patient DOB SSN

_____
ID/Subscriber Number Group Number

_____
Insurance Claims Mailing Address

_____
Insurance Phone Effective Date

EMERGENCY CONTACT

_____

Name Relationship Phone Number

I hereby authorize Pacific Women's Center, L.L.C., to furnish to your insurance company, employer or other payor, or their representatives, or either myself or the subscriber, or to the referring physician, all medical or financial information which may be requested concerning the patient's present illness, injury, or condition.

I hereby authorize my insurance benefits to be paid directly to Pacific Women's Center, L.L.C., and I understand that I am financially responsible for non-covered services. I agree to pay finance billing fee on any unpaid balance over 60 days.

Patient/Guardian Signature: _____ **Date:** _____

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Date: ____ /____/____ Main reason for visit: _____

Name: _____ **Birth date:** _____ Age: _____ Height: _____

□ Female □ Male □ Transgender (FtM) □ Transgender (MtF) □ Non-binary Pronoun: _____

Primary Care Physician (PCP): _____

Gynecological History:

First day of last normal menstrual period was: ____/____/____ Age of menopause, if applicable: _____

Age of first period: _____ Cramps: □ mild □ moderate □ severe Heavy flow: □ Yes □ No

How long are your menstrual cycles (ie: 28-30 days apart): _____days Average days of flow: _____days

Have you ever had an **abnormal** pap smear? □ Yes □ No when _____ where (City, State) _____

***If yes**: did you have a colposcopy?* □ Yes □ No *Did you have treatment? type:* _____

	Y	N		Y	N
Have you had cervical pre-cancer?			Have you had ovarian cancer?		
Have you had hormone replacement therapy?			Have you ever had a breast biopsy?		
Have you had the HPV/cervical cancer vaccine? (i.e. Gardasil)			Have you had BRCA testing or other genetic cancer screen?		
Did you complete the series (3 injections)?			*If yes, was it:* □ BRCA1+ □ BRCA2+ □ negative		

Are you sexually active □ Yes □ No □ Never

Present Birth Control Method: _____ ***If IUD**: when was it inserted* _____ *where* (City, State) _____

Screening History:

Date of last pap smear: ____/____/____ Date of last colonoscopy: ____/____/____

Date of last mammogram: ____/____/____ Date of last DEXA scan: ____/____/____

Pregnancy History:

Age of first birth _____

Number of: Pregnancies _____ Live Births _____ Miscarriages: *spontaneous* _____ D&C _____

Ectopic Pregnancies _____ Elective Abortions: *medication* _____ D&C _____

Child	DOB	Due Date	Hrs of Labor	C/S or vaginal del	Epidural Y/N	Sex M/F	Weight	Complications	Place of Birth (city, state)	Name of Child
1st										
2nd										
3rd										
4th										

Current Medications: *Please include herbs and/or nutritional supplements*

Medication	Dose	How Often	Medication	Dose	How Often

Allergies: *Please list any allergy you have to medication(s), food(s) and / or other substances*

Medication	Reaction	Medication	Reaction

Surgical History: *Please list surgeries or hospitalizations you have had in chronological order and approximate date.*

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

(OVER) ----------→

Medical History: *Check the appropriate box (and date if past event)*

	current	past		current	past
Anxiety			Chlamydia		
Depression			Gonorrhea		
Other mental health illness			Genital herpes		
Asthma			Genital warts (HPV)		
COPD			Pelvic inflammatory disease		
Sleep Apnea			Pain during intercourse		
Cancer – type			Chronic pelvic pain		
Chronic pain disorder			Uterine fibroids		
Chronic narcotic use			Ovarian cysts		
Diabetes			Frequent vaginal infection		
Eating disorder			Frequent bladder/kidney infection		
Heart disease			Deep vein thrombosis (DVT)		
High blood pressure			Pulmonary embolism (PE)		
High cholesterol			Breast biopsy		
Migraines			IBS		
Osteoporosis/osteopenia			Crohn's disease/Ulcerative colitis		
Seasonal allergies			Sexual abuse		
Seizures			Domestic violence		
Thyroid disorder			OTHER		

Family History: *Check the appropriate box (age of diagnosis if known)*

	Deceased (age)	Breast cancer	Colon cancer	Ovarian cancer	Heart disease	History unknown	High blood pressure	Diabetes	Brain damage	Stroke	Other
Mother											
Father											
Siblings											
Children											
Mom's Dad											
Mom's Mom											
Dad's Dad											
Dad's Mom											
Other											
Are you of Ashkenazi Jewish descent? □ **Yes** □ **No**											

Social History:

Occupation: _____

Do you have a healthy diet? □ Yes □ No Do you exercise? □ Yes □ No Type/frequency: _____

Smoking Status:

□ **Former**	□ **Current**	□ **Never**
Type: □ Cigarettes □ Vape □ Medical marijuana □ Recreational marijuana	*Type:* □ Cigarettes □ Vape □ Medical marijuana □ Recreational marijuana	
How many per day?	*How many per day?*	
When did you quit?		

Alcohol:

□ **Former**	□ **Current**	□ **Never**
How many drinks per week:	*How many drinks per week:*	
When did you quit?		

Recreational Drugs:

□ **Former**	□ **Current**	□ **Never**
Type:	*Type:*	
Amount:	*Amount:*	
When did you quit?		

Relationship Status: □ single □ married □ widowed □ significant other □ same gender □ multiple partners

Spouse/Partner's name: _____ Age: _____

Spouse/Partner's occupation: _____ Start date of current relationship: _____

Do you have other concerns or comments? _____

Name: _____ Birth Date: _____