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New Patient Welcome Packet
Adult

Greetings,

Welcome to Orchid Health! Our Health Clinics were founded on the belief that our state's rural communities deserve to have extremely high quality healthcare that is local, comprehensive, and takes the time to address what matters most to each individual.

We have brought together the following care team members to provide individualized, comprehensive care:

Primary Care Provider (PCP): Your PCP will help you think through important health decisions and may connect you with another member of the care team to make sure that you are getting the best care.

Medical Assistant (MA): Your Medical Assistant will often be the first person you talk with when you have a health concern and will work closely with your PCP to help support any standard ongoing healthcare needs.

Nurse Care Coordinator (RN): At Orchid, we have nurses that help you design a personalized Care Plan, including identifying your personal health goals and planning for any upcoming preventive health items.

Behavioral Health Provider (BH): Our Behavioral Health Providers are available to help with any mental, emotional, or behavioral health needs that you may have. This may include making lifestyle changes, dealing with sadness or loneliness, or problems at home or school.

Enclosed are our new patient registration forms. Please complete these forms to the best of your knowledge. Included is a *Medical Records Release Form*, which allows us to request your past medical records prior to your first visit. We ask that you complete this form and drop it off at our clinic as soon as possible.

In order for us to best serve you:

1. Please check in at the clinic 15 minutes prior to your scheduled appointment time.
2. Please bring your insurance card and your ID with you to your visit.
3. Please bring the bottles of any current medications you are taking.
4. If you need to cancel or reschedule your visit please provide us with 24 hours notice.

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We are ready to serve you at one of these locations! Welcome to the Orchid Health Family!

Oakridge: Clinic Phone number 541-782-8304

- We are located on Highway 58, right near the Pharmacy.
- Our hours of operation are: Monday, Tuesday, and Wednesday from 8am to 7pm and Thursday and Friday from 8am to 5pm. For after hours support, call our main clinic phone number.

Estacada: Clinic Phone number 503-630-8550

- We are located on the High School Campus, just to the right of the Estacada High School.
- Our hours of operation are: Monday and Tuesday from 8:30am to 7pm and Wednesday, Thursday, and Friday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

McKenzie River: Clinic Phone number 541-822-3341

- We are located at 54771 McKenzie River Highway, Blue River just off of the McKenzie River Hwy
- Our hours of operation are: Monday through Thursday from 8:30am to 5pm. For after hours support, call our main clinic phone number.

Fern Ridge: Clinic Phone number 541-234-3255

- We are located at 24934 Fir Grove Lane, Elmira, located in the parking lot of the High School.
- Our hours of operation are: Monday and Tuesday from 8am to 7pm and Wednesday through Friday from 8am to 5pm. For after hours support, call our main clinic phone number.

Sandy: Clinic Phone number 971-220-2701

- We are located at 37400 Bell Street, Sandy, located in the Student Health Center on campus.
- Our hours of operation are: Monday to Friday from 8am to 5pm. For after hours support, call our main clinic phone number.

FAQ - Frequently Asked Questions!

How do I make an appointment?

- Most people call our office to schedule an appointment.
- You can also request an appointment through our Patient Portal.

What is the Patient Portal?

- The Portal allows you to send messages directly to your Provider, instead of calling. It also allows you to see any lab and imaging results as soon as we receive them.
- You can find the portal link on our website: **www.orchidhealth.org** (upper right corner). - Ask any of our staff for help. We can send you an email link or set you up when you come in.

What days and hours are you open?

- *Oakridge:* Monday, Tuesday, and Wednesday 8-7, Thursday and Friday 8-5
- *Estacada*: Monday and Tuesday from 8:30-7, Wednesday 8:30-5, Thursday, and Friday from 8:30-5
- *McKenzie River:* Monday - Thursday from 8:30 am - 5:00 pm, closed on Fridays.
- *Fern Ridge:* Monday-Tuesday from 8-7, Wednesday-Friday from 8-5

What if I need to reach someone after the office is closed?

- Easy! Use the same phone number you normally call and listen for the option to reach our After-Hours Nurse Service.

How do I get my Prescription Refilled?

- The FIRST step is to call your pharmacy and ask them for a refill - they will then contact us directly if needed.
- If you are having any difficulty, please call us so we can resolve it for you. (Or use the Patient Portal!) - Any “controlled medication RX” needs to be given during an appointment. (This would include things like pain medication, certain anxiety or sleep medication, etc).

Can I have my blood tests drawn at Orchid?

- Yes, we draw labs for the patients who have *established* with us (even if ordered by others).

Do you do X-RAYS at Orchid?

- No, sorry, at this time, we do not have an X-RAY machine at any of our sites - but we can give you an order to do your test somewhere else.

How can I get my lab or X-RAY/imaging results?

- If you have a follow-up appointment scheduled, then your provider is probably planning to review your lab results at that time, but we will call you with anything really important so nothing gets overlooked.

What if I am worried about paying for my visit or labs?

- We don’t want money to stand in the way of your health care, so please talk to us about your concerns.
- Ask about our Sliding Fee Discount, too!

Do you see Kids? What about Babies? What about Seniors?

- Yes, Yes, and Yes!

ORCHID HEALTH REGISTRATION FORM

(Please print)

Legal Name: _____ Today's Date: _____
First - Middle - Last

Preferred name/name that you go by: _____Preferred Pronouns: _____

Legal Sex: Male/Female/Other Date of Birth (mm/dd/yy):_____ Social Security Number: _____

Mailing Address: _____ City: _____ State: _____ ZIP Code: _____

Home Phone: _____ Mobile Phone: _____ Consent to text? ☐ Yes ☐ No Email:

_____ Preferred communication method: _____

Preferred Language: _____

Race: (You can choose more than one if appropriate) ☐ White ☐ Black or African American ☐ Asian ☐ American

Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Hispanic or Latino Origin Ethnicity: ☐ Not

Hispanic/Latino ☐ Hispanic/Latino ☐ Other _____

Emergency Contact Name:_____ Relationship:_____ Phone Number:_____

INSURANCE INFORMATION

(please bring your insurance card to our receptionist)

Please indicate primary insurance name: _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): _____

Insurance ID #:_____ Group Number:_____

Name of SUBSCRIBER: _____ SSN: _____ Date of Birth: _____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

PERSON Financially Responsible for Bills and Payment:

Relationship to patient: _____ Name: _____ DOB: _____

Mailing Address: _____ ZIP Code: _____City: _____ State: _____

Best Phone Number: _____

CONSENT FORM

Consent for Treatment: I consent to medical treatment of medical services performed or prescribed by the attending or consulting medical providers at Orchid Health, and I agree to the performance of treatments or procedures which are considered necessary, routine, or advisable. An example of some treatments performed at Orchid:

- Routine physical exams, including sports physicals
- Early detection, diagnosis and treatment of illness and injury treatment of minor injuries
- Assessment and management of chronic health conditions
- Age-appropriate reproductive health
- Routine lab tests and Immunizations
- Health education, counseling, and wellness promotion
- Prescription medications if appropriate
- Behavioral health services
- Referral for health care services not provided by Orchid Health

Authorization of Payment: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive. I also authorize the release of any medical records necessary to allow the insurance company to pay for these services, within the guidelines of the HIPAA (Privacy) Laws. I fully understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. If I do not have active insurance, I agree to pay for services at the time they are received.

Notice of Privacy Practices: I acknowledge receipt of Orchid Health's Notice of Privacy Practices. This notice can be found on our website under patient forms, is available at the clinic upon check-in, and is otherwise available to me at any time upon request.

Patient Rights and Responsibilities: I acknowledge receipt of Orchid Health's Patient Rights and Responsibilities. These can be found on our website under patient forms, are available at the clinic upon check-in, and are otherwise available to me at any time upon request.

Consent to Access Historical Prescription/Pharmacy Records, and to Reach out to Local Hospital Networks to Access Health History Information: I authorize the release of my historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call: I consent to receive calls from Orchid Health for my protected healthcare and other services at the phone number(s) provided to the practice, including my wireless number. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Patient or Authorized Representative Name (Please print) _____

Date of Birth _____

If authorized representative please state relationship to patient _____

Signature _____ Date _____

AUTHORIZATION TO DISCLOSE INFORMATION

Patient Name: _____ Date of Birth:_____

Authorization to Disclose Information to Others:

Without specific permission, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e. spouse, parent, son, daughter, partner etc.).

I give permission to release the following information to the individuals listed below:

- ❑ All health information about me created or received by Orchid Health, including medical records, case or medical management, billing, payment, claims and enrollment, mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

- ❑ All health information **except for**: mental health, developmental disabilities, AIDS/HIV testing information or test results, substance abuse and alcohol treatment, and genetic testing.

Name	Relationship	Phone Number

Permission for non-guardian to consent for child's medical treatment (if patient is under 15 y/o):

- ❑ I give permission for the above listed individual(s) to provide consent for treatment on my behalf and to accompany my child to their medical appointments.

Personal Communication Methods:

As our patient, we may need to communicate with you outside of our clinic. To assure your privacy, we would like you to indicate whether it is OK or not to leave medical information (such as normal lab results) on a voicemail if we are unable to reach you.

Home Phone # _____

____ Do NOT leave messages
____ May leave call back numbers only
____ May leave messages with details

Mobile Phone # _____

____ Do NOT leave messages
____ May leave call back numbers only
____ May leave messages with details

TERM: This authorization will remain in effect for a period of **one year**. I can revoke this authorization in writing (at any time) as described in the Orchid Health Notice of Privacy Practices.

Signature _____ Date _____

Relationship to Patient: _____

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Medical Records Release

Patient Name_____ Former Name (if any) _____

D.O.B.: _____ Phone: _____

Address _____ City _____ State _____ Zip

I authorize information to be released FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

I authorize information to be released TO:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

The purpose of this request is:

☐ Referred Medical Care ☐ Transferring Care ☐ Personal ☐ Legal ☐ Other _____

Type of information to be released:

☐ Complete Medical Records *(Consists of the last 2 years of treatment unless otherwise specified)*

☐ Other (Please specify): _____

MUST be INITIALED to be included with records

_____ HIV/AIDs related records _____ Mental Health related records _____ Genetic testing information

_____ Drug/Alcohol** **PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

All records will be sent though fax unless otherwise indicated. I consent to the faxing of my medical records. All faxed documents contain a confidentiality statement, however, I understand confidentiality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

My signature indicates that I authorize the disclosure of the above information and understand the following:
I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment.
I understand I can cancel permission to use and disclose my information at any time in writing. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
I understand this change will not affect information that has already been shared.
I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/ AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.
I understand that I am allowed to receive a copy of this Authorization.

_____ _____ _____

Signature of Patient/Legally Responsible Person Relationship to Patient Date

☐ **Wade Creek Clinic**
535 NE 6th Ave • Estacada, OR 97023
F: (866) 669-3334 Ph: (503) 630-8550

☐ **Oakridge Clinic**
47815 Hwy 58 • Oakridge, OR 97463
F: (855) 313-2095 Ph: (541) 782-8304

☐ **Fern Ridge Clinic**
24934 Fir Grove Ln • Elmira, OR 97437
F: (833) 673-0252 Ph: (541) 234-3255

☐ **McKenzie River Clinic**
54771 McKenzie Hwy • Blue River, OR 97413
F: (833) 905-2303 Ph: (541) 822-3341

☐ **Sandy Clinic**
37400 Bell St • Sandy, OR 97055
F: (833) 903-3607 Ph: (971)220-2701

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ORCHID HEALTH MARKETING CONSENT FORM

How did you hear about us? (Please check one or provide details if not listed):
[ ] Online search
[ ] Word of Mouth
[ ] Social media
[ ] Print advertisement
[ ] Saw a Sign
[ ] Other: _____

I, _____, hereby grant consent to Orchid Health to send me marketing communications via email. I understand that I have the right to "opt out" of receiving such communications even if I have signed the opt-in option.

I understand and acknowledge the following:
1. Purpose: Communication that encourages you to use our services is considered marketing. We must obtain your authorization. The marketing communications may include information about Orchid Health services, promotions, events, newsletters, and other related healthcare materials.
2. Voluntary Participation: I have the right to choose whether or not to receive marketing communications from Orchid Health. Participation is entirely voluntary.
3. Privacy: Orchid Health will handle my personal information in accordance with its privacy policy and applicable laws and regulations.

Consent Options:
Please indicate your preference by checking the appropriate box below:

[ ] I consent to receive marketing communications from Orchid Health via email.
[ ] I do **NOT** wish to receive any Marketing Communications from Orchid Health.

Patient or Authorized Representative Name (Please print): _____
Date of Birth _____
If authorized representative please state relationship to patient _____

Signature _____ Date _____

New Patient Health History – Adult

Name _____ **Date of Birth** _____ **Today's Date** _____

Current Medical Concerns (what you would like to talk about today):

1. (most important) _____

2. _____

Please list any allergies you have to medications:
Name of Med Reaction

_____

_____

_____

Please list any medications that you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins (please write on back of page if needing additional space):
Name of Med Dose Directions (How often you take it)

_____

_____

_____

_____

Have you received the following immunizations (shots)? If yes, please indicate the approximate year received: Flu Shot No ❒ Yes ❒ Yr_____ Tetanus/Diphtheria No ❒ Yes ❒ Yr_____ Hepatitis A No ❒ Yes ❒ Yr_____ Shingles No ❒ Yes ❒ Yr_____ Pneumonia Shot No ❒ Yes ❒ Yr_____ Hepatitis B No ❒ Yes ❒ Yr_____ MMR No ❒ Yes ❒ Yr_____ Polio No ❒ Yes ❒ Yr_____ Other: _____No ❒ Yes ❒ Yr_____

WOMEN: Is there a chance you are pregnant? No ❒ Yes ❒
Have you been pregnant before? No ❒ Yes ❒ (How many times?) _____
When was your last menstrual period? _____

Have you ever had surgery? No ❒ Yes ❒ If YES, please list them (include the year if possible):

_____

Any hospitalizations? No ❒ Yes ❒ If YES, please list them (include the year if possible):

_____

Have you ever had any other serious injuries? No ❒ Yes ❒ If YES, please list them (include the year if possible):

_____

Have you had any of these TESTS? If YES, please indicate when:
Colonoscopy No ❒ Yes ❒ Year _____ Bone Density Test No ❒ Yes ❒ Year _____ Pap Smear No ❒ Yes ❒ Year _____ Mammogram No ❒ Yes ❒ Year _____ Heart Testing/Stress Test No ❒ Yes ❒ Year _____

FAMILY HEALTH HISTORY

Are you adopted? No ❒ Yes ❒ (If NO, please complete section below) P=Paternal M=Maternal Father Mother Grandmother Grandfather Brother Sister Aunt Uncle

	P/M	P/M	P/M	P/M	P/M	P/M	P/M	P/M
ADHD								
Alzheimer's Disease								
Alcoholism/Substance Abuse								
Aneurysm								
Anxiety and/or Depression								
Arthritis								
Asthma								
Bipolar or Schizophrenia								
Blood Disorder								
Cancer								
Diabetes								
Emphysema/COPD								
Heart Attack								
Hereditary Disorder								
High Cholesterol								
High Blood Pressure								
Kidney Disease								
Liver Disease								
Migraines								
Osteoporosis								
Seizures/Epilepsy								
Skin Cancer								
Stroke								
Sudden Cardiac Death								
Thyroid Disorder								

PERSONAL HEALTH HISTORY

ADHD or ADD	No ❒	Yes ❒	Endometriosis	No ❒	Yes ❒
Alcoholism/Substance Abuse	No ❒	Yes ❒	Fibromyalgia	No ❒	Yes ❒
Allergies/Hay fever	No ❒	Yes ❒	Gout	No ❒	Yes ❒
Anemia	No ❒	Yes ❒	GYN Problems	No ❒	Yes ❒
Anesthesia Complications	No ❒	Yes ❒	HIV	No ❒	Yes ❒
Anxiety Disorder or Recurrent Anxiety	No ❒	Yes ❒	Heart Problems	No ❒	Yes ❒
Arthritis	No ❒	Yes ❒	Hepatitis C	No ❒	Yes ❒
Asthma	No ❒	Yes ❒	High Blood Pressure/Hypertension	No ❒	Yes ❒
Autism Spectrum Disorder	No ❒	Yes ❒	High Cholesterol	No ❒	Yes ❒
Bipolar or Schizophrenia	No ❒	Yes ❒	Kidney Stones	No ❒	Yes ❒
Birth Defects or Inherited Disease	No ❒	Yes ❒	Kidney or Bladder Problems	No ❒	Yes ❒
Blood Transfusion	No ❒	Yes ❒	Liver Disease	No ❒	Yes ❒
Cancer	No ❒	Yes ❒	Migraines	No ❒	Yes ❒
Chicken Pox	No ❒	Yes ❒	Muscle, Joint, or Bone Problems	No ❒	Yes ❒
Clotting Problems/bleed too much	No ❒	Yes ❒	Osteoporosis	No ❒	Yes ❒
Depression	No ❒	Yes ❒	Reflux/GERD	No ❒	Yes ❒
Developmental or Behavioral Disorders	No ❒	Yes ❒	Seizures/Epilepsy	No ❒	Yes ❒
Diabetes or Pre-Diabetes	No ❒	Yes ❒	Skin problems (Rashes/Changing Moles)	No ❒	Yes ❒
Diverticulitis/Diverticulosis	No ❒	Yes ❒	Stomach Ulcers or Swallowing Problems	No ❒	Yes ❒
Domestic Violence	No ❒	Yes ❒	Stroke or TIA	No ❒	Yes ❒
Ear Infections - Chronic	No ❒	Yes ❒	Thyroid Problems	No ❒	Yes ❒
Ear or Hearing Problems	No ❒	Yes ❒	Tuberculosis or Positive TB Test	No ❒	Yes ❒
Eating Disorder like Anorexia or Bulimia	No ❒	Yes ❒	Vision or Eye Problems	No ❒	Yes ❒
Eczema	No ❒	Yes ❒	Other:	No ❒	Yes ❒
Emphysema/COPD/Chronic Bronchitis	No ❒	Yes ❒			

SOCIAL HEALTH HISTORY

Please answer the following questions to help us better understand how we may best support you. The information you provide will be used by your health care team to develop a plan to help you maintain or improve your health and well-being in the areas that you choose.

What is something that makes you happy or that you're proud of?

_____

Relationship Status: ❒ Married ❒ Divorced ❒ Single ❒ Widow(er) ❒ Other Partner

Employment Status: ❒ Working ❒ Unemployed ❒ Retired ❒ Intentionally Unemployed

What is (or has been) your usual occupation? (type of work) _____

Which of the following best describes your current living situation?

❒ Live alone in my own home ❒ Live in a household with spouse/others ❒ Temporarily staying with a relative or friend
❒ Temporarily staying in a shelter or homeless ❒ Other

Do you have problems with pests, mold, or a lack of heat, water or other utilities where you live? Yes ❒ No ❒

Is there anywhere you feel unsafe? Yes ❒ No ❒ Where?_____

If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need?

❒ I need a lot more help ❒ I could use a little more help ❒ I get all the help I need ❒ I don't need any help

Within the past 12 months, my household or I were worried whether our food would run out before there was money to buy more. ❒ Often true ❒ Sometimes true ❒ Never true

In the past 12 months, a lack of transportation has kept me from medical appointments or from doing things needed for daily living. ❒ Often true ❒ Sometimes true ❒ Never true

Do you have someone you connect with easily if you need help, or just need to talk? Yes ❒ No

❒ **Have you fallen two or more times in the past year?** Yes ❒ No ❒

Have you completed an Advance Directive or POLST form? Yes ❒ No ❒

During the past 4 weeks, how would you rate your health in general? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Smoking Status: ❒ Never smoked ❒ Former smoker ❒ Current everyday smoker ❒ Current some day smoker
Tobacco years of use: _____ How many packs/day: _____
Do you use any other forms of Tobacco? Yes ❒ No ❒ Do you use E-cigarettes? Yes ❒ No ❒

Would you like assistance in any of the above areas? Yes ❒ No ❒

If Yes, please explain: _____

Is there anything else we have missed that you feel we should know about your health?