New Patient Welcome Packet
Pediatric 6-17 years

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. Additionally, a *Controlled Substance Agreement* must be signed before the prescription of controlled substances by Orchid Health providers.

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.

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

Oakridge: Clinic Phone # 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 #.

Estacada: Clinic Phone # 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 8am to 7pm and Wednesday, Thursday, and Friday from 8am to 5pm. For after hours support, call our main clinic phone #.

McKenzie River: Clinic Phone # 541-822-3341

- We are located at 51730 Dexter St., Blue River just off of the McKenzie River Hwy
- Our hours of operation are: Monday through Thursday from 8am to 5pm. For after hours support, call our main clinic phone #.

Fern Ridge: Clinic Phone # 541-234-3255

- We are located at 24924 Fir Grove Lane, Elmira, located in the parking lot of the High School.
- Our hours of operation are: Monday through Friday from 8am to 5pm. For after hours support, call our main clinic phone #.

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 9:30-5, Thursday, and Friday from 8-5
- *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
- *Sandy:* Monday-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 best 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 - MINOR

(Please print)

Patient's Legal Name: ____Today's Date: _______________

First - Middle - Last

Preferred name/name that you go by: ______________________________

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

Parent/legal guardian #1 Name: __________________________Phone: _________________Lives with child: ☐ Yes ☐ No Parent/legal guardian #2 Name: _________________________Phone: _________________Lives with child: ☐ Yes ☐ No 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: __________________________

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CONSENT FORM - MINOR

Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age with the exception of 14-year-olds for sexual health and mental health services.*
*ORS 109.610, ORS 109.640, ORS 109.675.

I understand the following types of services are offered through Orchid Health:

- Routine physical exams, including sports physicals
- Early detection, diagnosis, and treatment of illness and injury treatment of minor injuries
- Management of Chronic Health Conditions
- Age-appropriate reproductive health
- Routine lab tests, Immunizations
- Prescription medications
- Mental health services
- Referral for health care services not provided by Orchid Health

I have read and fully understand the above information and have asked questions about anything not clear to me. I understand that I may revoke this consent at any time.

I (parent/legal guardian) ____give permission for my child, ____, to receive medical/mental health care at Orchid Health.

Authorization of Payment:

Parent or Guardian: I assign and authorize direct payment to Orchid Health of all insurance and plan benefits that are payable for service(s) I receive and authorize the release of any medical records necessary to facilitate my child's treatment to process claims and as otherwise permitted or required in the Notice of Privacy Practices. 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. ** SBHC's (School Based Health Clinic's) ,students receive care at no cost for Orchid Health Services.

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 child's historical health information, as accurate information is necessary for the provision of accurate and quality medical care.

Consent to Call: I consent to receiving calls from Orchid Health for my child's 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 Name ____ Date ______________________

Parent/Legal Guardian Signature ____________________________ Relationship to Patient ___________________

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 # ________________________________**Mobile Phone #** ____________________________________Do NOT leave messages ____Do NOT leave messages
____May leave call back numbers only ___May leave call back numbers only ___May leave messages with details ___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: ________________________

Designation of Another Person to Consent for Child's Medical Care

If I, (parent/legal guardian) ________________________________ , cannot accompany my child,

(child's name)____________________________ , to the Orchid Health Clinic, I give

permission to (person's name)__________________________ as follows (check one):

☐ I give permission for this person to seek medical treatment for my child(including any type of procedure) and provide consent for such treatment without having to
contact me.

☐ I give permission for this person to seek medical treatment for my child(including any type of procedure) and provide consent for such treatment if attempts to contact me are unsuccessful.

Expiration of Permission (check one):

☐ This form will remain in effect until revoked (by filling out a "revoke consent form")

☐ This form is VALID ONLY during the following time frame:

Effective date: _______________ / Expiration date: ________________

X ________________________________ ____________________________
(Signature of parent or legal guardian) (Date required)

Address ____

Home Phone ______________________ Work Phone ______________________

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 - Pediatric 6-17 years

Name ________________________________ **Date of Birth** _____________ **Today's Date** ______________

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

____

____

Please list any allergies you have to medications:
NAME OF MED Reaction

____

____

Please list any medications you currently take, including Over the Counter Medications, Herbal Supplements, or Vitamins:
NAME OF MED Dose Directions (How often given)

____

____

Immunizations
Do you follow the recommended CDC vaccination schedule? No ❒ Yes ❒

Please explain if altering schedule:____

Any hospitalizations? No ❒ Yes ❒ If yes, please explain below:

____

____

Please circle any surgeries: ❒ Heart ❒ Ear Tubes ❒ Tonsils/Adenoids ❒ Appendix ❒ Circumcision ❒ Frenulectomy (tongue clipping) ❒ Eye Surgery ❒ Hernia Repair, type: ___________ ❒ Other:_________________

<u>*For ages 12-17 only*</u> Who is filling out this portion of the form?

_________________________________ Sexually Active? No ❒ Yes ❒ If Yes, number of total partners (past and present): ___________ If YES, do you use condoms always? No ❒ Yes ❒

Do you use another form of Birth Control or Contraception? No ❒ Yes ❒

Menstrual Periods started at age ___________ Date of Last Menstrual Period _____________ Any past pregnancies? No ❒ Yes ❒

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

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								
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 and your family. The information you provide will be used by your health care team to develop a plan to help you maintain or improve you and your family's health and well-being in the areas that you choose.

Parents' Marital Status? ___________________________

Current living situation? ❒ House ❒ Apartment ❒ Foster care ❒ Temporarily staying in a shelter or homeless ❒ Other ____

Who do you/your child live with (check all that apply)? ❒ Mother ❒ Father ❒ Step-Parent ❒ Grandparent ❒ Aunt/Uncle ❒ Foster family ❒ Sibling(s) ❒ Other ____

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

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

Any special dietary needs (i.e. Gluten Free)? Yes ❒ No ❒ If yes, please specify: ____________________________________

Are you interested in getting help with parenting skills? Yes ❒ No ❒

Safety

Is there anywhere you feel you/your child are unsafe? Yes ❒ No ❒ If yes, please specify: ___________________________
Is your home "child proofed"? Yes ❒ No ❒
Is there anyone in the house who uses recreational drugs? Yes ❒ No ❒
Does anyone smoke at home (inside or outside)? Yes ❒ No ❒

Education and Activity

Grade in School __________________Name of School____
School Performance: ❒ At Grade Level ❒ Above Grade Level ❒ Needs Assistance
Sports? ❒ Yes ❒ No ______________________________Hobbies? ❒ Yes ❒ No
____________________________________Any problems with bullying? ❒ Yes ❒ No
Screen Time (TV/Computer/Phone) daily (on average)? ❒ None ❒ Less than one hour ❒ 1-2 hours ❒ 3 hours or more
How much time is spent outside daily (on average)? ❒ None ❒ A few minutes ❒ One hour ❒ More than one hour

For ages 12-17 only Who is filling out this portion of the form? _____________________________________

Smoking Status: ❒ Never smoked ❒ Former smoker ❒ Current every day 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 ❒

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

____

____

Thank you!