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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.

Community Health Worker (CHW): Our Community Health Workers are available to connect you with community resources, assist in navigating systems, help with insurance questions as well as help you advocate for your needs that can help improve overall health outcomes.

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 24934 Fir Grove Lane, Elmira, located in the parking lot of the High School.
- Our hours of operation are: Monday and Tuesday from 8:30am to 7pm and Wednesday through Friday from 8:30am 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 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: _____

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Designation of Another Person to Consent for Minor 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.

☐ I give verbal permission to Orchid Health Staff for my child to seek medical treatment.

_____	_____	_____
Witness name (printed)	Witness Signature	Date

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)

Home Phone _____ Work Phone _____

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Medical Records Release

Pa﷿ent Name_____ Former Name (if any) _____

D.O.B.: _____ Phone: _____

Address _____ City _____ State _____ Zip

I authorize informa﷿on to be released FROM:	**I authorize informa﷿on to be released TO:**
Name: _____	Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____

The purpose of this request is:

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

Type of informa﷿on 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 _____ Gene﷿c tes﷿ng informa﷿on

_____ Drug/Alcohol** **PROHIBITED RE-DISCLOSURE: This informa﷿on has been disclosed to you from records protected by Federal Confiden﷿ality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this informa﷿on without the specific writen consent of the person to whom it pertains or as otherwise permited by 42 CFR Part 2. A general authoriza﷿on for the release of medical or other informa﷿on 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 confiden﷿ality statement, however, I understand confiden﷿ality at the receiving end cannot be guaranteed. ☐ YES ☐ NO

My signature indicates that I authorize the disclosure of the above informa﷿on and understand the following:
I understand that I may choose not to sign this authoriza﷿on 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 informa﷿on at any ﷿me in wri﷿ng. 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 informa﷿on that has already been shared.
I understand that federal and state law protects my health informa﷿on. However, my informa﷿on could be shared with agencies or businesses that may not be covered by this law. They could then share my informa﷿on with others. I understand that they cannot share informa﷿on regarding HIV/ AIDS, mental health treatment, alcohol and drug treatment or gene﷿c tes﷿ng unless I give them permission by ini﷿aling this permission above or as otherwise permited by law.
I understand that I am allowed to receive a copy of this Authoriza﷿on.

_____ _____ _____

Signature of Pa﷿ent/Legally Responsible Person Rela﷿onship to Pa﷿ent 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: _____

For ages 12-17 only 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 ❒			

As part of whole person care offered at Orchid Health, we have Community Health Workers (CHWs) available to support you with connection to resources beyond the medical clinic.

Name _____ DOB _____ Today's Date _____

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

   _____

2. **Do you currently live in a shelter or have no steady place to sleep at night?**

   Yes ❒ No ❒

3. **Do you think you are at risk of becoming homeless? OR at risk of facing eviction?**

   Yes ❒ No ❒

4. **Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.**

   Often true ❒ Sometimes true ❒ Never true ❒

5. **Within the past 12 months, you worried whether your food would run out before you got money to buy more.**

   Often true ❒ Sometimes true ❒ Never true ❒

6. **Do you have trouble getting transportation to medical appointments?**

   Yes ❒ No ❒

Please indicate if you have concerns about any of the following:


Alcohol/Substance Use ❒


Child or Elder Care ❒


Clothing ❒


Dental Care ❒


Education ❒


Employment ❒


Health Insurance ❒


Pests / Mold / Air Quality ❒


Prescription Costs ❒


Social Connection ❒


Utility Costs ❒


Vision Care ❒

Would you like assistance with any of the above areas? Yes ❒ No ❒ Not Sure ❒

I would like to opt out of this screener. ❒