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Exceptional, local healthcare

New Patient Welcome Packet

Pediatric 6-17 years

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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.

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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 #.

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

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: _____

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 except for family planning, sexually transmitted disease services, and certain 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, 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 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 also authorize the release of any medical records necessary to facilitate my 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.

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, is available at the clinic upon check-in, and is 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.

Parent/Legal Guardian Signature _____ Date _____

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 # _____

___ 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: _____

MEDICAL RECORDS RELEASE

Patient Name _____ Former Name (if any) _____

Current Address _____ D.O.B. _____

_____ S.S.# _____

City, State, Zip

Best Contact Phone _____

I Authorize Information Released FROM: (please print)

Clinic/Doctor's Name: _____ Address:_____

City, State, Zip_____

Please Send My Records TO: (fax preferred circle one)

Orchid Health	**Orchid Health**	**Orchid Health**	**Orchid Health**
Wade Creek	***Oakridge***	***McKenzie River Clinic***	***Fern Ridge Clinic***
534 NE 6TH Ave.	47815 Highway 58	54771 McKenzie Hwy	24934 Fir Grove Lane
Estacada , OR 97023	Oakridge, OR 97463	Blue River, OR 97413	Elmira, OR 97437
Fax: (503) 630-8551	Fax: (541)782-5823	Fax: 1 (833) 905-2303	Fax: (541) 508-4135
Ph: (503) 630-8550	Ph. (541) 782-8304	Ph. (541) 822-3341	Ph. (541) 234-3255

Purpose of Release

❒ Establishing New PCP ❒ Sharing Health Information (from Consultant/Specialist) ❒ Personal Use ❒ Legal

Type of Information To Be Released- Initial **ALL** that apply

____**Complete** Medical Records ____ Include Mental Health Records ____Include Confidential Records/HIV or other

____ Include Records relating to Drug or Alcohol Treatment:_____

____Other (specify): _____

This authorization will expire one year from the date of the signature below.
I understand that I can change my mind about this authorization at any time by writing to the health care provider or to Orchid Health, but that any information already transferred will remain in our Confidential Medical Record System.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that Orchid Health may redisclose the information if it is relevant for consultation, or if you request we transfer your records to another location.
- I am allowed to receive a copy of this Authorization.

Signature _____ Date _____

Relationship to Patient: _____

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 P/M	Grandfather P/M	Brother	Sister	Aunt P/M	Uncle 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!