

Welcome to our Office!

Thank you for visiting us at Mountain View Medical Center. We are happy to have you as a new patient and want to help maintain your health.

We hope to be able to advise you on your healthcare needs in the future. As Family Physicians and Nurse Practitioners we can work with you on your acute, short-term health problems, any of your long-term, chronic health issues, and we can advise you on National Standards for preventative healthcare. We refer obstetrical services to local OB-Gyns.

For your convenience, our office is open 7:00 a.m. until 5:00 p.m. Monday-Friday. There is a physician on call for our practice at all times. We admit patients to Tuality Community Hospital in Hillsboro.

Family Medicine means that we treat all ages of patients, from newborn infants through the more mature, elderly years. Much of our job satisfaction comes from watching families in our community grow over time. All of our providers live in the Tualatin Valley area and are active members of their respective communities.

Our office also provides lab and X-ray services. These services have been added for your convenience. Many patients take advantage of an early morning fasting blood draw a few days prior to their scheduled physical exam. We have a Bone Densitometer to test for Osteoporosis, thinning of the bones, before our patients develop spinal compression fractures or hip fractures.

Among many diseases, we have a special interest in Diabetes, Osteoporosis, and Back Injuries and we have comprehensive programs set up for the care of these conditions.

Our team of front office staff, nurses, and technicians are always happy to help. We consider them family as most have been with our office for many years.

Finally, we will bill your insurance company as a service to you. We work hard and dedicate a number of full-time staff to this operation. As with all offices, billing issues may arise. Please feel free to speak with our billing department with your concerns. *If you have any difficulties, please schedule an appointment to speak with one of our Providers so together we can untangle these often complicated issues in the least stressful way.*

Again, it is our pleasure to have you as a new patient. Let us know along the way about anything we can do to help make your visit more informative and productive.

Sincerely yours,

Timothy J. Gray, D.O.
T.J. Gray II, D.O.
Karen A. Kirwan, FNP-C
Robert Giusti, FNP-C

TJGII: ajv

PATIENT REGISTRATION

Mountain View Medical Center
 1909 Mountain View Lane - Suite 200
 P.O. Box 189
 Forest Grove, OR 97116-0189
 (503) 359-4773

(Please complete all sections. Print or type.)

Please present your insurance card at the time of your service.

ACCOUNT NUMBER		PATIENT INFORMATION			DATE OF FIRST APPOINTMENT	
NAME Last First MI			PATIENT STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other			
			<input type="checkbox"/> Employed <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Full-Time Student			
PATIENT'S BIRTHDATE		SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER		Is another member of your family or a relative a patient in our office? _____	
HOME ADDRESS City State Zip					EMAIL ADDRESS	
					()	
MAILING ADDRESS					CELL NUMBER	
					()	
EMPLOYER'S NAME & ADDRESS					BUSINESS PHONE NUMBER	
					()	

RESPONSIBLE PARTY INFORMATION (Who Is Responsible For This Bill?)			
(Complete this section if someone other than patient will be responsible for bill)			
NAME Last First MI			
DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP TO PATIENT	
HOME ADDRESS City State Zip			HOME PHONE NUMBER
			()

SPOUSE INFORMATION	
NAME Last First MI	
SOCIAL SECURITY NUMBER	
EMPLOYER'S NAME & ADDRESS	
BUSINESS PHONE NUMBER	
()	

CONTACT INFORMATION		
NAME (WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY WHILE AT OUR OFFICE)	RELATIONSHIP	PHONE NUMBER
		()
NAME (NEAREST RELATIVE NOT LIVING WITH YOU)	RELATIONSHIP	PHONE NUMBER
		()
NAME (NEAREST FRIEND NOT LIVING WITH YOU)		PHONE NUMBER
		()
NAME (REFERRED BY)		PHONE NUMBER
		()
NAME (DENTIST)		PHONE NUMBER
		()

PRIMARY		INSURANCE INFORMATION		SECONDARY	
INSURED'S NAME (Last Name, First, MI)		INSURED'S NAME (Last Name, First, MI)		INSURED'S NAME (Last Name, First, MI)	
PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
INSURED'S ID NUMBER	POLICY OR GROUP NUMBER	INSURED'S ID NUMBER	POLICY OR GROUP NUMBER	INSURED'S ID NUMBER	POLICY OR GROUP NUMBER
INSURED'S DATE OF BIRTH ____/____/____ SEX <input type="checkbox"/> M <input type="checkbox"/> F		INSURED'S DATE OF BIRTH ____/____/____ SEX <input type="checkbox"/> M <input type="checkbox"/> F		INSURED'S DATE OF BIRTH ____/____/____ SEX <input type="checkbox"/> M <input type="checkbox"/> F	
EMPLOYER'S NAME OR SCHOOL NAME		EMPLOYER'S NAME OR SCHOOL NAME		EMPLOYER'S NAME OR SCHOOL NAME	
INSURANCE PLAN NAME OR PROGRAM NAME		INSURANCE PLAN NAME OR PROGRAM NAME		INSURANCE PLAN NAME OR PROGRAM NAME	
IS THERE ANOTHER HEALTH BENEFIT PLAN?					
<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete Secondary Insured's column on right					

ASSIGNMENT FOR INSURANCE BENEFITS AND AGREEMENT TO PAY	
<p>In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with the extension of credit, please be advised of the following policies which apply in this office. If the amount paid by the insurance company is insufficient to cover charges, I understand that I will be responsible for the remaining balance. In the event it becomes necessary to refer any account to a collection agency, the undersigned promises to pay the reasonable fees and collection costs, even though no suit is filed. If a suit or action is filed, the amount of the reasonable attorney's fees shall be fixed by the court or courts in which the suit or action, including any appeal therein, is tried, heard, or decided. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.</p> <p>ASSIGNMENT OF BENEFITS: I hereby authorize the release of any medical information necessary to process any insurance claims. I hereby authorize payment directly to the physician for medical services provided.</p>	
DATE: _____	PATIENT SIGNATURE (OR PARENT, IF MINOR) _____

Mountain View Medical Center Patient and Family Information Form

Please fill out all information for **Patients In Our Clinic:**

Family Information	
Self/ Parent:	Birthdate:
Spouse/Parent:	Birthdate:
Children:	Birthdate:
Children:	Birthdate:
Children:	Birthdate:
Children:	Birthdate:
Children:	Birthdate:
Do all family members live at the same address?	
If not, who? Write other address:	

List other relatives who are **Patients in Our Clinic:**

Relationship

Date: _____

Mountain View Medical Center

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Patient's Responsibility for Payment

As a service to our patients, Mountain View Medical Center (MVMC), will submit charges for medical treatment to the patient's insurance company, where applicable, and to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic. If you do not have any medical insurance, you will be responsible for the bill at the time of service. Monthly statements will be sent when there is a patient balance and payment is expected on a regular basis.

MVMC may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

If the patient participates in an HMO or PPO that requires co-payment, the patient MUST pay the co-payment at the time of the appointment or a \$10 fee will be assessed in addition to the co-payment.

If the patient has health insurance coverage through the Oregon Medical Assistance Program (Welfare) and wishes our clinic to provide immunizations, we do not participate in their immunization program and any expenses incurred as a result of immunizations being provided through our clinic will be billed directly to the patient or the parent or guardian if the patient is a minor.

If the patient has a worker's compensation claim, MVMC will submit the claim information to the employer's insurance carrier providing the patient provides MVMC with the name of the insurance carrier, the date of injury, and, if available, the claim number and a copy of the 801 form. Patients must keep track of their own mileage and prescription costs for reimbursement by the insurance provider. A fee will be charged to you if you request the clinic compile this information.

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs, even if there is a pending lawsuit.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at MVMC for medical care and treatment. I agree to pay all medical expenses within 30 days of the date I am billed for those expenses, unless other arrangements have been made with MVMC.

If I do have insurance, I authorize release of all my medical information to my insurance company and I authorize payment of all medical benefits by my insurance company to MVMC.

Patient's Signature
(Parent or guardian, if patient is a minor)

Date of Signature

1909 Mountain View Lane, Suite 200
P.O. Box 189
Forest Grove, Oregon 97116-0189
503) 359-4773 * Fax (503) 359-3809

ACKNOWLEDGMENT AND CONSENT

I understand that Mountain View Medical Center (referred to below as “This Practice”) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative, and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice’s Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____ (Patient)	Date: _____
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-or-

By: _____ (Patient Representative)	Date: _____
Description of Representative’s Authority: _____	

For Office Use Only

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

FAMILY HISTORY:

Do you know of any blood relative that has or had: (give relationship)

Cancer_____	Heart Disease_____
Rheumatic Fever_____	Tuberculosis_____
High Blood Pressure_____	Epilepsy_____
Stroke_____	Bleeding Tendencies_____
Colitis_____	Alcoholism_____
Goiter/Thyroid Problems_____	Leukemia_____
Diabetes_____	Asthma_____
Osteoporosis_____	

ROUTINE CARE:

FEMALES ONLY:

Age started menses: _____
 Date last menses started: _____
 Total number of pregnancies: _____
 Total number of births: _____
 Total number of miscarriages: _____
 Total number of terminated: _____
 If menopause, age/year of onset: _____
 Last Pap smear: _____
 Last mammogram: _____

EXAMS:

Date of last eye exam: _____
 Date of last dental exam: _____
 Last Tetanus shot: _____
 Last Tuberculosis test: _____
 Last general blood test: _____
 Marital status: S M D W
 Number of children and ages: _____

HABITS:

Do you smoke? Yes No
 Cigs/chew/other per day _____
 What is your caffeine intake/day?

 Do you drink alcohol? Yes No
 Number of drinks/day? _____
 Do you use over-the-counter or prescription meds for reasons that are not medical? If yes, please list:

 Do you use any illegal drugs that are not medical? If yes, please list:

MALES ONLY:

Last physical Exam: _____
 Last Prostate Exam: _____
 Last Prostate Blood test (>35yo)

FOR OFFICE USE ONLY

PREVENTION:

IMMUNIZATIONS	DATES GIVEN						
Flu Shot							
Pneumovax							
Tetanus							
Instructed to come in for a tetanus booster with an injury within 24 hours							
Hepatitis A (series)							
Hepatitis B (series)							
Immunization Record requested							
Others:							