

## Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
(Last, First, Middle Initial) (circle one)

Marital Status: ( ) Child ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other \_\_\_\_\_

If married spouse's name \_\_\_\_\_ Home Phone( ) \_\_\_\_\_

Mailing Address \_\_\_\_\_  
(P.O. Box or Street address) (City) (State) (Zip code)

Physical Address \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work Phone( ) \_\_\_\_\_

Patient's SS # \_\_\_\_\_ Drivers License # \_\_\_\_\_ State \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F  
(Last, First, Middle Initial) (circle one)

Address \_\_\_\_\_  
(P.O.Box or Street address) (City) (State) (Zip Code)

Relationship to Patient: \_\_\_\_\_ Phone( ) \_\_\_\_\_

SS # \_\_\_\_\_ Employer \_\_\_\_\_ Driver's License# \_\_\_\_\_ State \_\_\_\_\_

## Emergency Information

Name of Friend or Relative NOT living with you

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone( ) \_\_\_\_\_

Address \_\_\_\_\_  
( P.O. Box or Street Address) (City) (State) (zip code)

## Financial Agreement and Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees for such treatment. I accept full responsibility for payment thereof, and I hereby assign to La Pine Community Health Center any and all insurance benefits due me to the full extent of my financial obligation to said provider. I understand that I may be billed for non-cancelled appointments. In the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees, should this be required.

It is agreed that payments will not be delayed or withheld because of any insurance coverage and all proceeds of insurance are assigned and/or payable to this office where applicable. (A copy of this assignment is as valid as the original.)

**Agreement:** The above information is for the purpose of obtaining credit and is warranted to be true. I authorize the creditor or his agent to make a credit investigation, including employment verification. I hereby authorize the release of pertinent medical records to my insurance carrier(s).

Signature \_\_\_\_\_

La Pine Community Health Center  
51600 Huntington Rd.  
La Pine, Oregon 97739

541-536-3435 fax: 541-536-8047

**La Pine Community Health Center**  
**Insurance Information**

**Insurance**

**Company(Primary)** \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex:  M   F   
(circle one)

Relationship to patient \_\_\_\_\_ SS Number \_\_\_\_\_

**Insurance**

**Company(Secondary)** \_\_\_\_\_ ID # \_\_\_\_\_ Group# \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex:  M   F   
(circle one)

Relationship to patient \_\_\_\_\_ SS Number \_\_\_\_\_

The Providers and Staff of La Pine Community Health Center have your healthcare as our first priority. After we provide healthcare services to you, we will bill your insurance for you. We understand that at times insurance billings can seem complicated, and we have billing staff available to help you with questions you may have.

The following is a list of the health insurance companies that La Pine Community Health Center participates with:

Blue Cross Blue Shield-	Tricare
Central Oregon Independent Health Services (COIHS)	Medicare
Clear Choice Health Plans	ODS Healthplans
Lifewise	DMAP
Healthnet Health Plan Oregon	(Department of Medical Assistance Programs)
PacificSource	
Providence Health Plans (EPO) (PPO)	

We participate with these insurance companies through mutually agreed upon contracts that allow their participants better coverage, and ensures that we can maintain the quality of care our patients deserve.

If you do not see your insurance company on the list, this means we do not participate with that particular company. We will bill all insurance companies, but we have no control over the dollar amount a non-participating company will pay for your services. Payment has been set by these companies without our input and as a result, you, the patient can possibly be left with an account balance higher than expected.

It is important that you check with your insurance before you have any medical services rendered so that you will be informed of what the possible financial outcome for that service will be. We can provide you with any information you may need to verify with your insurance company.

I have read and understand the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed

\_\_\_\_\_  
Date