



**Southern Oregon Internal Medicine**  
*Rogue Valley Physicians, P.C.*

**2900 Doctors Park Drive, Suite 200**  
**Medford, OR 97504**  
**Phone: (541) 282-2200**  
**Business Fax: (541) 282-2237**

***Please fill in the following information completely: (Please Print)***

**1) PATIENT INFORMATION:**

Date: \_\_\_\_\_  
 Maiden name: \_\_\_\_\_

Name: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 If minor child, parent(s) name: \_\_\_\_\_  
 Mailing address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Married    Widowed    Divorced    Separated    Single  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Social Security number: \_\_\_\_\_

**2) RESPONSIBLE PARTY: If same as # 1, check box**

Person responsible for paying bill: \_\_\_\_\_  
 Relationship to above person:    Spouse    Mother    Father    Other: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Social Security number: \_\_\_\_\_

**3) SPOUSE INFORMATION: If same as # 2, check box**

Spouse's name: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance: \_\_\_\_\_ Group No.: \_\_\_\_\_  
 Social Security number: \_\_\_\_\_

**4) INFORMATION FOR PHYSICIAN:**

Friend/neighbor who can be reached in case of emergency: \_\_\_\_\_  
 Person or doctor who referred you to this clinic: \_\_\_\_\_  
 If self-referred, how did you choose us:    Newspaper    Phone Book    Other: \_\_\_\_\_

**AUTHORIZATION TO PAY-RELEASE MEDICAL INFORMATION**

I hereby authorize Southern Oregon Internal Medicine the release of any medical information necessary to process a claim. I hereby assign payment directly to Southern Oregon Internal Medicine all payments due from my insurance company. I understand that I am financially responsible for the charges and should it become necessary to collect monies in court, all court costs and attorney fees are the responsibility of the patient. A service charge of 1.5% will be assessed on accounts past due.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Parent or responsible party, if patient is minor child)

**NOTE: We bill secondary insurance companies with which we contract. If you have questions regarding insurance, please speak with our office manager or one of our insurance specialists.**

**To control billing costs, we request that co-pays, deductibles, and non-covered services be paid at the time of service. Please indicate how you wish to pay for today's services:**

**METHOD OF PAYMENT:**    Cash    Check    Visa    Mastercard    Medicaid/OHP  
**If Medicaid (open card), show your card to the receptionist at each visit.**

**SOUTHERN OREGON INTERNAL MEDICINE  
2900 DOCTORS PARK DRIVE  
MEDFORD, OR 97504**

**PLEASE INDICATE WHICH MEDICAL INFORMATION YOU  
AUTHORIZE TO BE DISCLOSED VIA THE TELEPHONE FROM  
OUR OFFICE:**

- |                     |  |
|---------------------|--|
| _____               | APPOINTMENTS                           |
| _____ LAB RESULTS   | _____ PATHOLOGY RESULTS                |
| _____ EKG RESULTS   | _____ PRESCRIPTION/SAMPLES INFORMATION |
| _____ X-RAY RESULTS | _____ MAMMOGRAM RESULTS                |

**INFORMATION REGARDING THE ABOVE CHECKED ITEMS  
MAY BE DISCLOSED TO THE FOLLOWING:**

\_\_\_\_\_ SPOUSE/NAME: \_\_\_\_\_

\_\_\_\_\_ SIGNIFICANT OTHER: \_\_\_\_\_

\_\_\_\_\_ FAMILY MEMBERS/NAMES: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ CARETAKER/NAME: \_\_\_\_\_

\_\_\_\_\_ ANSWERING MACHINE

\_\_\_\_\_ NO ONE BUT MYSELF

**THANK YOU! WE WANT TO BE SURE WE HOLD YOUR MEDICAL  
MATTERS IN A PRIVATE FASHION ACCEPTABLE TO YOU!**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print your name:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**SYSTEMS REVIEW**

**Please check all symptoms that currently apply.**

**General:**

- Too hot or cold
- Poor appetite
- Always tired
- Trouble sleeping
- Lack of exercise
- Always thirsty
- Crying spells
- Depressed
- Anxiety or stress
- Hopeless outlook
- Lose temper often
- Considered suicide
- Weight loss or gain
- Sexual difficulty

**Head and Neck:**

- Frequent headaches
- Neck pains
- Lumps or swelling
- Difficulty swallowing

**Eyes:**

- Blurred vision
  - Seeing double or halos
  - Eye pain
  - Watering or itching
  - Wear eyeglasses
- Date of last eye exam:  
\_\_\_\_\_

**Ears:**

- Difficulty hearing
- Hearing aides
- Buzzing or ringing
- Earaches or drainage
- Frequent infections

**Mouth:**

- Dental problems
- Frequent sores
- Swelling or lumps
- Hoarse voice or sore throat

**Skin:**

- Rashes or sores
- Change in mole
- Lumps or swelling
- Bleed or bruise easily
- Itching

**Neurological:**

- Seizures
- Numbness
- Tingling
- Trembling
- Fainting spells
- Change in handwriting

**Cardiovascular:**

- Chest pains
- Dizziness
- Racing heart
- Shortness of breath
- Swollen ankles
- Leg cramps
- Irregular pulse
- Poor circulation

**Respiratory:**

- Wheezing
- Frequent cough
- Cough up phlegm or blood
- Sit up to sleep
- Trouble breathing

**Digestive:**

- Frequent indigestion
- Frequent belching
- Nausea or vomiting
- Spit up blood
- Constipation or diarrhea
- Black or gray stools
- Rectal pain or bleeding
- Change in stools

**Urinary:**

- Frequency or urgency
- Burning or pain
- Trouble starting
- Wet pants or bed
- Dark or bloody urine
- Nighttime urination

**Male Genital:**

- Lumps on testicles
- Painful testicles
- Prostate trouble
- Discharge
- Burning

**Female Genital:**

- Irregular periods
  - Abnormal bleeding
  - Vaginal discharge
  - Itching or odor
  - Severe cramping
  - Hot flashes
  - Menopause
  - Lumps in breast
  - Had a C-section
  - Had abortion
  - # of pregnancies
  - # living children
- Date last period: \_\_\_\_\_
- Date last pap: \_\_\_\_\_

**Musculoskeletal:**

- Joint pain
- Swollen joints
- Aching muscles
- Weakness
- Tingling
- Handicapped

**Nose:**

- Frequent nosebleeds
- Sinus problems, congestion

**Comments:**

---

---

---

---



## **Southern Oregon Internal Medicine** FINANCIAL POLICY

Thank you for choosing Southern Oregon Internal Medicine for your health care needs. The following is a statement of our Financial Policy which we request that you to read and sign prior to your visit with us.

### **REGARDING YOUR INSURANCE**

It is not possible for a medical practice to become familiar with the details for every health insurance plan it encounters as there are over 6,000 registered insurance companies and plans. Therefore, it is your responsibility as the patient or legally responsible adult to know your benefits, what is covered, what is excluded and how much will be the patient responsibility. We will submit insurance claims as a courtesy to our patients with insurance. However, you are responsible for our charges.

We are required by law and/or insurance company policy requirements that you pay any deductible, co-pay and balance owed at the time of service. Please remember that we can only estimate the amount to be paid by an insurance company as they make payments based on their fee schedule. Their fee schedules may differ from our charges. While we attempt to help you in every way possible to obtain your maximum allowable insurance benefits, the insurance contract is between you and your insurance company and does not replace your responsibility for your account. If your insurance company has not paid your claim within 45 days, we will ask you to pay the balance in full.

### **SECONDARY INSURANCE**

Having more than one insurer does not necessarily mean that your services are covered at 100%. We may bill your secondary carrier as a courtesy. You are responsible for any balance after insurance(s) has cleared.

### **USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

### **PRIVATE PAY**

We ask that our patients without insurance pay a minimum of ½ of their charges at the time of service. The remainder of this balance must be paid in 3 equal monthly payments. Special arrangements can be made with the advance approval of the clinic manager or billing department.

#### **Southern Oregon Internal Medicine**

2900 Doctors Park Drive, Medford OR 97504 | P: (541) 282-2200 | F: (541) 282-2237  
A Rogue Valley Physicians, PC clinic | [www.roguevalleyphysicians.com](http://www.roguevalleyphysicians.com)

**MEDICAID/OHP PATIENTS**

Oregon Health Plan/Medical Card patients, this office requires that you show your current medical card before each visit and that you are currently assigned to the appropriate physician. We will re-schedule your appointment if you fail to comply with this policy and do not present with the current card.

**SERVICE CHARGES**

We reserve the right to apply a finance charge in the amount of 1.5% per month or 18% annually to all account balances after 90 days as allowed by state law. A fee of \$25.00 will be assessed to your account for any check returned due to non-sufficient funds. A fee of \$20.00 may be assessed to your account for a missed appointment.

WE ACCEPT PERSONAL CHECKS, MONEY ORDERS, VISA, MASTERCARD, DISCOVER AND CASH

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

**I have read the Financial Policy. I understand and agree to the terms of this Policy:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship