Rudy R. Greene M.D. FACR

Board Certified Rheumatology

A Non Narcotic Office

268 S. Pacific Hwy. Talent OR 97540

541-535-5523 Phone

541-535-5368 Fax • 888-454-4451 Fax

Dear New Patient,

Welcome to our practice! We have scheduled an appointment for you, at the date and time listed above. Please complete and bring the enclosed forms (or mail them prior to your appointment). Also, please remember to bring VALID ID, your insurance card(s), prescription card and medication list with you. *Please bring your COMPLETED paperwork with you, or we will not be able to see you at that time and will have to reschedule your appointment.*

As a new patient, we block out extra time for you so that Dr. Greene can do a full evaluation, ask questions and perform an examination. If you cannot keep your appointment, we require at least TWO FULL BUSINESS DAYS' NOTICE. Due to our high new patient referral demand, *should you fail to show up for your appointment, we will not set up another appointment, nor will we see you as a patient.* We may not always do courtesy calls to remind you of your appointment, so please mark your calendar accordingly.

We also like for our patients to be aware that we are a non-narcotic office. This means that we do not prescribe narcotic.

Also please be advised that we *do not do disability evaluations* nor do we fill out disability forms, nor do we communicate with lawyers. However our notes will be available, should you need them.

Our office hours are Monday-Thursday between the hours of 9:00 a.m. and Noon and from 1:00 p.m. and 5:00 p.m. Our office is closed on Fridays.

Thank you for the opportunity to work with you.

Sincerely,

The Staff

PATIENT INFORMATION

FORM MUST BE FILLED OUT COMPLETELY

OR WE CAN NOT BILL YOUR INSURANCE

Patient Name_____ Date of Birth ___/___/___Male☐ Female☐

Address: _____

City_____State_____Zip_____Phone_____Cell_____

Social Security _____ Email address _____

Present Employer_____ Work Number _____

Married_____ Single _____ Divorced _____ Widow_____ Domestic Partner_____

Primary Doctor_____ Phone _____

Referring Doctor_____Phone _____

Preferred Pharmacy_____ Phone _____

Emergency Contact _____Phone _____

Primary Insurance: **_____**

Insured's name_____ Date of Birth_____

ID Number_____ Group Number _____Phone _____

Relationship to Insured: Self_____ Spouse_____ Child_____

Secondary Insurance: **_____**

Insured's Name_____ Date of Birth_____

ID Number_____ Group Number _____Phone_____

Relationship to Insured: Self_____ Spouse_____ Child_____

Ok to leave a message on home phone? ☐ yes ☐ no

SIGNATURE **_____ Date_____**

Patient Name: _____

PAST MEDICAL HISTORY: If you have had any of the following problems, circle it and write the date you were first told you had that problem.

Diabetes _____ Heart attack _____ Hepatitis _____
High blood pressure _____ Angina (chest pains) _____ High cholesterol _____
Rheumatic fever _____ Heart murmur _____ AIDS _____

Other Medical Problems (Please List): _____

_____

_____

Surgeries (list and give approximate dates): _____

_____

_____

HABITS:

SMOKING- *I am a current smoker* □ *I am a non-smoker:* □
Pack(s) per day _____ Yrs smoked? _____ Yr. Quit: _____

ALCOHOL- *I currently drink alcohol* □ *I am a non-drinker* □
Average alcohol use: _____

COFFEE- *I currently drink coffee* □ *I do not drink coffee* □
Daily coffee use: _____

RECREATIONAL DRUGS- *I am a current drug user* □ *I do not use drugs* □
Current drug use: _____

FAMILY MEDICAL HISTORY: If Living (age) If Deceased (age at death)

Father: _____
Mother: _____
Brothers and Sisters: _____

_____

_____

Number of children, and their ages: _____

_____

(cont)

If your children have health problems, please list : _____

_____

_____

_____

Has any blood relative had any of the following problems? (please circle)

Rheumatoid Arthritis	Osteoarthritis	Osteoporosis	Heart attack
Other types of Arthrit	Diabetes	High blood pressure	High Cholesterol
Sudden death	Lupus		

Additional comments _____

_____

_____

_____

_____

_____

_____

Who is at home with you? _____

_____

Last grade of schooling completed? _____

_____

What recreational interests do you have? _____

_____

List any vitamins or supplements you may be taking.

_____

_____

_____

_____

_____

Signature X _____ DATE: _____

MEDICATION LIST

PATIENT NAME:_____

ALLERGIES: _____

PHARMACY:_____**Date:** _____

MEDICATION	HOW MANY MILLIGRAMS	HOW OFTEN YOU TAKE IT

Rudy R. Greene, M.D.
Rheumatology
268 South Pacific Hwy
Talent, OR 97540
Ph# 541-535-5523 **Fax# 541-535-5368**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient: _____***DOB***_____

I consent to the release of medical information (Records):

To: From:

_____ _____

_____ _____

_____ _____

_____ _____

Information to be released:

☐ Standard Problem List, Medication Summary, Progress Notes, health history
☐ X-Ray Reports Only. Date(s) _____

☐ Laboratory and Pathology reports only. Date(s) _____

☐ Other tests or studies. List type of test or study_____

☐ Other. Specify _____

In addition to the general authorization to release medical records, I further authorize the release of the following information if it is contained in my medical record (initial release if authorized):

☐ Drug and alcohol abuse
☐ Mental Health
☐ Information related to diagnosis/treatment of HIV

Purpose of disclosure:_____

This authorization is valid for six months after the date of signature. The authorization may be revoked at any time(but not retroactive to a release of information made in good faith) by the undersigned if providing written notice of revocation.

_____ _____
Signature of patient or Legally Authorized Representative Date

AUTHORIZATION
TO USE/DISCLOSE HEALTH INFORMATION

I authorize: ***Dr. Rudy R. Greene*** to use and disclose a copy of the specific health and medical information described below regarding:

_____

(*Name of patient*)

Consisting of*:* **_____**

(Any of my medical information that Dr. Rudy R. Greene deems necessary)

To: _____

(Please include any friend or family member that you give us permission to speak with about your health care other than your primary or referring physician)

For the purpose of: _____

(My future health care.)

(Please describe each purpose of disclosure, or state "as requested by the individual")

Your health care and payment for that health care cannot be conditioned upon receipt of this signed authorization unless your health care or treatment is for the purpose of:

(1) Creating health information about you to be disclosed to a third party; or
(2) For the purpose of research.

You have the right to revoke this authorization at any time, provided that you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this authorization, please send a written statement to: **Office Manager, 268 S. Pacific Hwy., Talent, OR 97540,** ***that identifies the date you signed this authorization, the recipient of the information identified in this authorization, and state that you are revoking this authorization.***

This authorization will remain in effect until the above patient revokes this or until one year after the patient's last appointment with Dr. Rudy R. Greene, whichever comes first.*I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.*

By_____ ***Date_____***

AUTHORIZATION FOR MEDICAL TREATMENT AND AGREEMENT OF FINANCIAL RESPONSIBILITY

I, _____, authorize Dr. Rudy Greene and his medical staff to administer treatment as deemed necessary for my benefit. I also authorize the use of any anesthetics and/or medications, with the exception of_____(allergy or other reason). I acknowledge that no guarantee or assurance has been made to the results that may be obtained.

I also understand that it is my responsibility to complete all tests (i.e. blood work, x-ray, MRI, CT, etc.) that Dr. Greene necessarily prescribes. If I do not complete the test for any reason, I release Dr. Greene of all responsibility.

I understand that it is my (the patient) responsibility to verify with my health insurance company that the services being provided to me by Dr. Greene's office are covered and authorized by my insurance company. I understand that it is also my responsibility to have a referral in place, if it is required by my health insurance company. This is to include any referral needed to see any other doctor that Dr. Greene may feel necessary for me to see to help with any of my medical concerns. I understand that it is my responsibility, as well, to verify with my health insurance company that I am covered for tests (such as those referenced in the preceding paragraph) that Dr. Greene may order.

I accept financial responsibility for all charges that are not paid by my health insurance company. I understand there will be a finance charge of 1.5% per month (18% annual percentage rate) assessed to unpaid balances after 90 days. I accept financial responsibility for all charges that are not paid by my health insurance company. I understand that any copay and deductible will be due at the time of service.

OUTSIDE LABS:

Dr. Greene often utilizes an out-of-area lab, RDL, for specialty labs. These may not be covered under your insurance plan, or may be considered "out of network." It is the patient's responsibility to check with your insurance carrier and determine if these are covered under your plan. RDL Laboratory 1-800-338-1918

I hereby certify that I have read, fully understand, and agree to this Authorization for Medical Treatment and Agreement of Financial Responsibility.

Responsible Party Signature_____ Date_____

If patient is a minor, signature of parent/guardian_____

Relationship to patient_____

***The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rudy R. Greene, MD or insurance company to release any information required to process my claims*.**

ACKNOWLEDGMENT AND CONSENT

I understand that ***Rudy R. Greene M.D.*** (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 the 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 from my health insurance, 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 will read the copy of the Notice of Privacy Practices in the office.

By: _____ Date: _____
(Patient)

By: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____

CANCELLATION POLICY

Please be assured that we value your time and hope that you value ours. We make every reasonable effort to stay on schedule throughout the day, while we remain committed to providing each patient with the highest quality of care.

If you need to reschedule an appointment, we will be happy to accommodate you, but we do ask for at least TWO FULL BUSINESS DAYS advance notice. You may also leave a message with our answering service after hours. However, please note that we are closed on Fridays and would not consider a cancellation on Friday as sufficient notice. We charge a $50.00 fee for an appointment not canceled within TWO FULL BUSINESS DAYS of the appointment time. After the second missed appointment without appropriate notice, we will no longer be able to see you in our practice.

We may not make confirmation calls prior to your appointment. Please mark your calendars accordingly.

If you are a new patient and you miss your first appointment, we will not be able to reschedule the appointment without the physician's approval.

Signature _____ **Date** _____

Print Name _____

If patient is a minor, signature of parent or guardian _____

Relationship to patient _____

DIRECTIONS

Coming from North

Take I-5 South to Talent Exit 21. Make a Right onto Valley View Rd and go to 2nd traffic signal. Make a Left onto South Pacific Hwy. Get into Right Hand Lane. Go 0.2 miles. You will see an S.O.S. building. We are the next driveway after that.

Coming from South

Take I-5 North to Talent Exit 21. Make a Left onto Valley View Rd. Go to 2nd traffic signal. Make a Left onto South Pacific Hwy. Get into Right Hand Lane. Go 0.2 miles. You will see an S.O.S. building. We are the next driveway after that.

For Your Convenience
We now accept
MasterCard, Visa, and Discover

Your co-pay, if applicable, is due at time of service. We will not bill you for your co-pay amount.

Thank you for your cooperation,

The Staff of Dr. Greene, M.D.