COMPASS
FAMILY MEDICINE
Your Guide to Better Health

PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION				
Patient Last Name:	First:	Middle Initial:	Marital Status	
Is this your legal name? Yes / No	If not, what is your legal name?		Birth Date:	Sex:
Street Address:			Phone Number:	
P.O. Box:	City:	State:	ZIP Code:	
Email:				
Appointment confirmation preference:				
Preferred Pharmacy:				

PAYMENT POLICY		
Compass Family Medicine, Inc. is a self-pay clinic. We do not bill insurance of any kind. Payment is due at time of service in the form of cash, check or debit/credit card.		
Name of party responsible for charges, if different than the above:	Address (if different):	Phone No.:
Patient's relationship to Responsible Party:		

EMERGENCY CONTACT		
Name:	Relationship to patient:	Phone no.:

VIRTUAL VISITS

Virtual visits are available to established patients. To use this service, you agree to the limitations associated with videoconferencing. Some conditions may not be treated virtually and may require an in-person visit. You acknowledge that your reliance on this service is solely at your own risk and you assume full responsibility for all risk associated therewith.

Initials _____

PERSONAL RESPONSIBILITY

The above information is true to the best of my knowledge. I understand that I am financially responsible for all visits and services provided to me or my minor child(ren) by Compass Family Medicine.

X _____ X _____

Patient/Guardian Signature ***Date***

*By submitting this form electronically I agree that my digital signature is legally binding.

Send forms to: compassfamily@myupdox.com

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1215 C Street, Hood River, OR 97031

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Ben Pate, PA-C to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). The Notice of Privacy Practices provided to me describes such uses and disclosures in more detail.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Compass Family Medicine and Ben Pate, PA-C reserve the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to your provider.

With this consent, Compass Family Medicine and Ben Pate, PA-C or their designated employee may call my home or other alternative location and leave a message on voice mail or in person in reference to any issue that assists in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory tests results, among others.

With this consent, Compass Family Medicine and Ben Pate, PA-C may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders cards, results, reports and patient statements. I have the right to request that my provider restrict how they use or disclose my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by that agreement.

By signing this form, I am consenting to allow Compass Family Medicine and Ben Pate, PA-C to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Compass Family Medicine and Ben Pate, PA-C may decline to provide me with treatment.

X_____
Patient Name

X_____
Patient Signature

X_____
Relationship to Patient

X_____
Signature of Guardian if applicable

X_____
Today's Date

Other's with whom we may share your medical information (e.g. family member or caretaker)

Name	Phone	Relationship

*By submitting this form you agree that your digital signature is legal and binding.