Today's Date:	Primary Physician:

PATIENT INFORMATION (PLEASE PRINT)

Patient's last name: First:	Middle:	Phone number: Is it okay to leave a detailed voice message?

Preferred Name	Pronouns	Email address:	Birth date:	Sex: ◯ M ◯ F

Address:

Person responsible for bill:	Birth date: Relation to patient:	Billing address (if different from patient):	Phone number:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone number	Can we leave a message?

In accordance with Oregon law, when you are referred for care outside of our clinic, we at Baker Allergy, Asthma & Dermatology, are required to notify you that you may have the test or service done at a facility other than the one recommended by your physician or health care provider.

Oregon law says (ORS 441.098):

- A referral for a diagnostic test or health care treatment or service shall be based on the patients' clinical needs and personal health choices.
- A health practitioner shall not deny, limit, or withdraw a referral solely because the patient chooses to have the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- A health practitioner or the practitioner's designee shall provide notice of patient choice at the time the patient establishes care with the practitioner and at the time the referral is communicated to the patient.
- The oral or written notice of patient choice shall clearly inform the patient:
  - (a) That when referred, a patient has a choice about where to receive services; and
  - (b) Where the patient can access more information about patient choice.
- The patient has a choice and when referred to a facility for a diagnostic test or health care treatment or service the patient may receive the diagnostic test or health care treatment or service at a facility other than the one recommended by the health practitioner.
- If the patient chooses to have the diagnostic test, health care treatment or service at a facility different from the one recommended by a practitioner, the patient is responsible for determining the extent of coverage or the limitation on coverage for the diagnostic test, health care treatment or service at the facility chosen by the 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 authorize Baker Allergy, Asthma, and Dermatology or insurance company to release any information required to process my claims.

I agree that I have access to a copy of the Notice of Privacy Practices through our website and hard copies in our lobby.

_______________________________________   _______________________________

Patient/Guardian Signature   Date

JAMES W. BAKER, MD, LLC
DBA: BAKER ALLERGY, ASTHMA & DERMATOLOGY

PATIENT RESPONSIBILITY FOR PAYMENT

To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our business manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Baker Allergy, Asthma & Dermatology will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.

Baker Allergy, Asthma & Dermatology does not verify in advance the patient's insurance. Patients should contact their insurance companies directly for any coverage questions they may have. 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 deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for notifying the office at the time of service. If the patient participates in Washington DSHS, the patient will be responsible for all services. Baker Allergy, Asthma & Dermatology does not accept Washington DSHS.

Baker Allergy, Asthma & Dermatology does not treat worker's compensation injuries or illnesses. 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

If the patient participates in a plan that requires co-payment, the patient must pay the co-payment at the time of the appointment.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Baker Allergy, Asthma & Dermatology for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan may require a referral from my Primary Care Physician to cover the visits to a Specialty Physician. If Baker Allergy, Asthma & Dermatology at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for all charges incurred (including lab and Xray).

I hereby assign to Baker Allergy, Asthma & Dermatology all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired during my examination and treatment.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Baker Allergy, Asthma & Dermatology to release to my insurance company any information acquired during my examination or treatment. I also agree to full responsibility for all expenses incurred by or on account of myself or this patient and hereby assign to Baker Allergy, Asthma & Dermatology all insurance benefits due to the fullest extent of my financial obligation to said office.

____ ____________________

Patient Signature (Parent or Guardian if patient is a minor) Date

____

Patient Printed Name (or printed name of Parent or Guardian if patient is a minor)

Baker Allergy, Asthma and Dermatology

9495 SW Locust Street, Suite A
Portland, OR 97223

Patient Information

______________________________ ______________________________
Name Date of Birth

____
Address

____
City State Zip

Communication Preferences

______________________________ □ Consent to leave detailed voice message
Preferred contact phone number □ Consent to text

HIPAA Privacy Authorization

I understand that Baker Allergy Asthma and Dermatology may still use and disclose protected health information as indicated in the Notice of Privacy Practices.
Would you like to give someone else access to your medical records?
□ Yes, I would like to give access to the following friends, family, or caregivers: □ No

______________________________ Full Name (First and Last) or Entity ______________________________ Address ______________________________ Relationship	______________________ Phone Is it okay to leave a detailed message? ______________________	Authorized to Disclose: □ Access to medical information (i.e., appointments, diagnoses, treatment plans, chart notes, test results) □ Access to billing information (i.e., balances, payment plans, claims processing, receipts)
______________________________ Full Name (First and Last) or Entity ______________________________ Address ______________________________ Relationship	______________________ Phone Is it okay to leave a detailed message? ______________________	Authorized to Disclose: □ Access to medical information (i.e., appointments, diagnoses, treatment plans, chart notes, test results) □ Access to billing information (i.e., balances, payment plans, claims processing, receipts)

- This Authorization is being granted at the request of the individual.
- Unless otherwise revoked, this Authorization expires 12 months after the date of signing this form.
- I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.
- I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.
- I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I release Baker Allergy, Asthma & Dermatology, their employees and agents, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

______________________________ ______________________________
Signature of the Patient Date

______________________________ ______________________________
Signature of the Legal Representative Relationship to Patient