Jon E. L. Ermshar, MD
Erin McKenzie-Carter, PA
Gail Giltner, FNP

1716 Williams Hwy.
Grants Pass, OR. 97527
541-474-6053
Fax 541-474-4527

Patient: ____
Last name First Name Middle Initial

Sex: _______________ Name of Spouse: ____

Street Address: ____

Mailing Address: ____

City: ___________________________ State: __________________________ Zip: _____________________

Date of Birth: ___________________SSN:________________________ Home Phone___________________

Business Phone: ________________________ Cell Phone: ____

Patient Employed By: ______________________________ Preferred Pharmacy______________________

Race (Please circle one): White, American Indian, Asian, Black/African American, Hawaiian/Pacific Islander or Other Race

Ethnicity (Please circle one): Hispanic/Latino, **Non**-Hispanic/Latino, Declined

Tobacco Status (Please circle one): Current, Former or Never

If Patient Is A Minor:

Father's Name ____________________________________ DOB ___________ SSN___________________

Address ____ Phone ___________________________

Mother's Name____________________________________ DOB ____________ SSN___________________

Address ____ Phone ___________________________

Name of Primary Insurance ____

Subscriber's Name ____________________________ ID# ___________________ Grp# ________________

Nearest Relative or Friend not living at your address

Name _________________________________ Phone________________ Relationship ________________

Previous Doctor ____

Patients are responsible for all fees regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. I authorize Jon E.L. Ermshar M.D. to release to my insurance company or its intermediaries, any information needed for insurance claims. I permit a copy of this authorization to be used in place of the original. This authorization remains in effect unless a request by the patient is received in writing.

Signature ____ Date__________________________

ACKNOWLEDGEMENT AND CONSENT

I understand that WellSpring Family 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 as described in a Notice of Privacy Practices.

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.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered a copy of the Notice of Privacy Practices which are available at the front desk.

By:_____________________________________DOB:______________Date:____________________
(Patient or authorized signature if under 18 years of age)

WellSpring Family Practice

Patient Intake Questionnaire

This is one of the most important documents you will create for your medical providers. We will use the information you put on this form to create and complete your Clinical Summary. Please be as complete and accurate as possible. You may need to collect information from other sources to complete this form, such as your prescriptions, Immunization record and past medical records.

Demographics:

Name:______________________________ DOB:__________ SS#:______________

Ethnicity:______________________________ Race:____________________

Gender: Male - Female

Address:____

City:______________ State:_____ Zip: ________Ph#1:__________Ph#2:__________

Employer:____Ph#:__________

Emergency Contact Name:____________________________ Ph#:__________

Previous Primary Care Provider:________________________ Ph#:__________

Allergies/Sensitivities:

Substance:	Reaction:	Onset Date:

Medications:

Medication/Supplement:	Dose:	Route:	Frequency:	Indication:	Active:

Habits/Substance Use:

Substance-Type:	Amnt:	Frequency:	Onset Yr:	Quit?:
Tobacco: cigarette, pipe, cigar, chew				
Alcohol: beer, wine, mixed drinks, liquor, whiskey				
Substance: marijuana, cocaine, meth				
Substance-benzodiazepine, opiates, other				
Activity: gambling, computers, television, games				

Past Medical History:

Disease Name:	Onset Date:	Treatments/Notes:

Past Surgical History:

Procedure Name:	Surgeon:	Date:	Reason for Procedure:

Family Medical History:

Disease Name:	Relative:	Age:	Treatments/Outcome:

Social History:

Marital Status: Status/Spouse Name/Date	
Children: Sex/Age	
Education: Level/Degree	
Occupation: Type/Name of Employer	
Diet: Type/Limitations	
Activity Level: Capacity/Exercise/Limits	
Code Status: Full Code/Life Support/Advance Directive	
Spiritual Belief System: Type/Active/Date	

Immunization History: (Please bring immunization record)

Immunization:	Last Booster/Shot Date:	What Facility:

Reproductive History: (For Women Only)

Age of 1st Menstruation: ______	Sexually Active? Yes / No	Pregnancy #: _______
Last Menstruation: ____________	Birth Control=______________	Delivered #: ________
Cycle: Regular/Irregular	Monogamous? Yes / No	Premature #: _______
Duration of Menses=______days	Hormones? Yes / No	Miscarried #: _______
Flow: Light/Medium/Heavy		Aborted #: __________

Review of Systems: (This portion of the form will need to be updated each visit to our office.)

Circle the symptoms that apply to you. Add any that you believe are not listed below.

Fatigue, Fever, Chills, Body aches, Sweating

Eye discharge, Eye pain, Change in vision, Dry Eyes, Flashing lights in vision

Masses, Pain, Headaches, Lightheadedness, Nasal congestion, Nose bleeding, Dental problems, Sore Throat, Breath odor, Ear pain, Snoring, Dry mouth

Breast lumps, Breast tenderness, Nipple discharge

Chest pain, Irregular heart beats, Rapid heart rates, Fainting, Lower extremity swelling, Looking blue, Aching when you walk, Slow heart rate

Shortness of breath, Wheezing, Cough, Hoarseness, Hemoptysis, Sputum/Phlegm

Nausea, Vomiting, Diarrhea, Constipation, Heartburn, Abdominal pain, Jaundice, Black/Tarry Stool, Bloating, Bleeding, Change in Appetite

Urinary urgency, Frequency, Pain with urination, Urination at night, Blood in urine, Incontinence, Weak urinary stream, Irregular Menstruation, Hot flashes, Impotence

Rash, Itching, Dry skin, New skin lesions, Acne

Muscular weakness, Incoordination, Tingling, Numbness, Difficulty concentrating, Memory difficulties, Speech difficulties, Seizures, Tremors, Loss of balance

Joint pain, Joint swelling, Muscle pain, Muscle weakness, Muscle cramps, Skeletal deformity, Loss of function, Masses/Tumors

Increased Urine output, Increased Thirst, Hair loss, Constipation, Improper hair growth, Feeling cold, Feeling warm, Change in weight, Loss in height

Anxiety, Depression, Delusions, Feeling confused, Compulsive behaviors, Suicidal ideas, Homicidal ideas, Withdrawn, Angry

Easy bleeding, Easy bruising, Black spots on body, Enlarged lymph nodes, Tender lymph nodes

Sinus allergy symptoms, Allergic skin rash, Frequent Illness

Signature: ______________________________ Date: ______________

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1716 Williams Hwy.
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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I hereby authorize: to disclose to:

______________________________________ ____
Name of Disclosing Party Name of Recipient

_____________________________________ ____
Address Address

_____________________________________ ____
City State Zip City State Zip

Records and information pertaining to:

________________________________ _____________________ _____________
Patient name: Social Security Number: Date of Birth:

____ _______________
Address: Telephone number:

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here ________________________ (Date)

Revocation: This authorization is also subject to written revocation by the Patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Redisclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Specify Records: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☐ **Medical Information** ____________ Initial
- ☐ **Psychiatric Information** ____________Initial
- ☐ **Drug/Alcohol Information** ____________Initial
- ☐ **Results of HIV Test** ____________Initial
- ☐ **Genetic Records** ____________Initial

A copy of this authorization is a valid as the original. Patient has a right to a copy of this authorization

____________________**Date** ____ **Signature**

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to WellSpring Family Practice. When you schedule an appointment with WellSpring Family Practice we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective November 1, 2014 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**.

- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee**.

- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from WellSpring Family Practice.

- Any new patient who fails to show for their initial visit will not be rescheduled.

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.

- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact WellSpring Family Practice 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages left at either location are acceptable.

WellSpring Family Practice Williams Highway (541) 474-6053
WellSpring Family Practice Hawthorne (541) 955-0607

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

____________________________ ____________________________

Signature (Parent/Legal Guardian) Relationship to Patient

____________________________ ____________________________

Printed Name Date

WellSpring
Family Practice

Financial Agreement

WellSpring Family Practice (WSFP) appreciates the opportunity to provide health care services to you. We recognize that payment for services has become more complex over the years. Ensuring proper payment on your account is a joint responsibility between those financially responsible and the provider. Therefore, we would like to briefly outline your role in this process.

By executing this agreement, you are agreeing to be held financially responsible for all services received in accordance with this policy.

Financial Responsibility
You are obligated to assure WSFP that your insurance company (if applicable) will pay for the services rendered, or you will pay for these services yourself. WSFP will send statements as a courtesy to the address on file and the balance is to be paid within 30 days.

Insurance
Your coverage is an arrangement between you and your insurance plan. It is your responsibility to understand your coverage. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of eligibility, coverage, and total balance payable from you. All copayments or payments toward deductible will be collected on the day services are provided if applicable. Any remaining balances will be due and payable within 30 days of your insurance plan determining your responsibility.

Self-Pay
If you do not have insurance coverage or you are covered by a plan that we do not participate with, you will be required to pay the day services are provided and a 25% discount will be available for those that qualify.

Returned Checks
A fee of $35 will be charged for any checks returned by the bank for insufficient funds.

Insurance Coverage Key Points

- It is your responsibility to understand your coverage including required copay and deductibles.
- Payment of copay/deductibles will be collected the same day as services are provided.
- If there is a remaining balance after your insurance processes you are responsible for payment.
- Unpaid balances may be subject to 9% APR interest and may require assignment to a Collection Agency and/or dismissal from WSFP.

Delinquent Accounts
If you are unable to pay your balance within 30 days please contact our office regarding your account. The number will also be provided on your statement. If we do not receive payment in full or contact from you regarding your unpaid balance within 60 days you may be held responsible for Finance Charges of 9% APR, potential assignment to a Collection Agency, dismissal from WSFP, and/or any attorney fees incurred in resolving your account.

By my signature, I indicate that have read this policy, understand its content, and agree to its provisions.

________________________________	______________________________
Printed Name of Person Financially Responsible	Date
________________________________	______________________________
Signature	Patient Name / Account Number

1716 Williams Highway ♦ Grants Pass, OR 97524 ♦ Phone (541) 474-6053 ♦ Fax (541) 474-4527

NOTICE OF PRIVACY PRACTICES
for JON E.L. ERMSHAR, M.D., P.C. dba
WELLSPRING FAMILY PRACTICE

Revision Date: November 1, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Officer of our office at (541) 474-6053.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practices and that of (1) any healthcare professional authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

YOUR MEDICAL INFORMATION. We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or health care providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that medical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to medical information about you; and (3) follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. “Use” is what we do with your information in this office. “Disclose” means sharing your information with others outside this office. All of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care.
- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations**. We may use and disclose medical information about you as reasonably necessary. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- **To the Department of Health and Human Services (HHS)**. We must disclose your medical information when requested by HHS when it is undertaking a compliance investigation, review, or enforcement action.
- **To You**. We must disclose your medical information to you when you request it in writing, as described below. We may disclose your medical information to you in other situations.
- **Opportunity to Agree or Object**. We may disclose your medical information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider’s professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.
- **Incidental Use**. Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization**. We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Public Interest and Benefit Activities**. We may disclose medical information about you for 12 national priority purposes, including when required by law, such as statute or court order; for public health activities, such as providing immunization records to a school with a parent’s permission; to government agencies regarding victims of abuse; to health oversight agencies to carry out legally authorized audits and investigations; pursuant to court orders and subpoenas that meet certain requirements; to law enforcement as described below; to a coroner or

medical examiner; as necessary to facilitate organ or tissue donation and transplantation; for research purposes under certain circumstances; to prevent a serious threat to your health and safety or the health and safety of the public or another person; for certain essential government functions; and for workers' compensation or similar programs.

- **Law Enforcement**. We may disclose your Health Information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Limited Data Set**. In certain situations we may disclose your medical information within a limited data set for research, healthcare operations, and public health purposes. A limited data set is medical information about you from which certain identifying information about you, your relatives, household members, and employers has been removed.
- **Fundraising**. We may disclose certain medical information about you for fundraising purposes. We may also contact you for fundraising purposes. If you do not wish to be contacted for this purpose, you may opt out of receiving such communications.

DISCLOSURES THAT REQUIRE AUTHORIZATION FROM YOU.

- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information**. Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other**. Other uses and disclosures not described in this notice will be made only with your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU. You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Amend**. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for this office.
  To request an amendment, complete and submit an AMENDMENT REQUEST form to the Privacy Officer.
  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the medical information kept by or for the office; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.
- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you.
  To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.
- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request unless (1) the disclosure is for the purposes of carrying out payment or healthcare operations, and (2) the protected health information pertains to an item or service which you, or another person other than your health insurance, have paid for in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
To request restrictions, you may complete and submit the REQUEST FOR LIMITATION AND RESTRICTION OF PROTECTED HEALTH INFORMATION to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.

- **Right to Request Confidential Communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
  To request confidential communications, you may complete and submit the PATIENT'S REQUEST TO LIMIT CONFIDENTIAL COMMUNICATIONS to the Privacy Officer. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact the Privacy Officer.
- **Right to Receive Notice of Breach**. You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact the Privacy Officer. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.