DATE: _____ **DATE OF BIRTH:** _____

NAME: _____ **EMPLOYEE NUMBER:** _____

REASON FOR VISIT: _____

VISIT RELATED TO EMPLOYMENT? *YES* _____ *NO* _____

Employer Name: _____

Employer Contact Name: _____ Employer Phone: _____

If Work Comp, Date of Injury: _____

If Work Comp, have you completed an 801 Form? YES _____ NO _____

VISIT RELATED TO AUTO ACCIDENT? *YES* _____ *NO* _____

For all Motor Vehicle Accident visits, Your Care will collect a deposit equaling the cash pay office visit. You will be refunded the deposit upon payment of claim from the insurance company.

If yes, Date of Injury: _____

Auto Insurance Company: _____

Claim Adjustor Name: _____

Claim Adjustor Contact: _____

Claim Number: _____

ESTABLISHED PATIENT:

Has your contact information changed: YES _____ NO _____ *If yes, please provide updated contact information:*

_____

PRIMARY HEALTH CARE PHYSICIAN: _____ **PREFERRED PHARMACY:** _____

YOUR CARE, LLC - GENERAL POLICIES*:*

- ❖ I understand that Your Care does not treat and manage chronic pain.
- ❖ I understand that Your Care does not treat migraine headaches with narcotics.
- ❖ I understand that Your Care is not a designated Primary Care clinic, however we can address some primary care issues on a limited basis.
- ❖ I understand that for Oregon Health Plan, by contract, Your Care cannot do any primary care nor can Your Care process referrals for Oregon Health Plan.
- ❖ I understand that if this is a Worker's Compensation issue, any changes in my treatment plan and/or prescriptions require an appointment.
- ❖ I understand that I am ultimately responsible for payment regardless of the reason for my visit.
- ❖ I understand that if this is related to a Motor Vehicle Accident, Your Care will collect a deposit and require claim information.
- ❖ I understand that Your Care will pre-authorize and verify insurance coverage, including deductible and copay amounts. Your Care will collect required payments when I check-in and any further balance due whether insurance or cash pay, upon check-out.

I, THE UNDERSIGNED, UNDERSTAND AND ACCEPT THE YOUR CARE GENERAL POLICIES AND VERIFY THAT THE ABOVED INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT SIGNATURE OR RESPONSIBLE PARTY **DATE**