WILLAMETTE VALLEY ENDOCRINOLOGY
MARTIN L. BASSETT, M.D., P.C.
CHRISTIAN DUREN, M.S., C.D.E., P.A.-C.
REBECCA CROWLEY-HUEY, P.A.-C.
KRISTEN GEHRING, P.A.-C.
TAUNI CARTER, P.A.-C.

700 BELLEVUE S.E., SUITE 240
SALEM, OREGON 97301

PHYSICIAN AND P.A.'s of
ENDOCRINOLOGY AND METABOLISM

TELEPHONE (503) 399-8105
FAX (503) 581-5351

Please return this packet within two days of receiving it. Thank you!

(Complete pages 3-8 and 11)

- **REGULAR BUSINESS DAYS ARE: MONDAY-FRIDAY**
- **REGULAR BUSINESS HOURS ARE: 8:30AM-NOON AND 1:30PM 4:30PM**
- **DON'T FORGET TO VISIT US ONLINE AT WWW.WVENDO.COM!**
- **YOU MAY RETURN YOUR NEW PATIENT PACKET VIA MAIL OR FAX**
- **PLEASE READ EACH PAGE THOROUGHLY**

Welcome to Willamette Valley Endocrinology! Please let us introduce our team of five medical professionals who take pride in providing excellent care to each of our patients:

Martin L. Bassett, MD, PC

Dr. Bassett has a Bachelor's degree in Pharmacy from OSU and later earned his Medical degree at OHSU. He has practiced Endocrinology for nearly 30 years. He worked in Kazakhstan for 10 years as a medical missionary and currently enjoys volunteering for the Salem Free Clinic as well as teaching classes for the medical community.

Kristen M. Gehring, PA-C

Kristen has a Bachelor's degree in Biology from Linfield College and completed her Master's degree at OHSU. She has also practiced Endocrinology since graduation. She is fluent in Spanish and worked in Honduras for 2 years prior to her training. She currently enjoys working with our Spanish-speaking patients in addition to volunteering at the Hillsboro Free Clinic.

Tauni Carter, PA-C

Tauni grew up in Pendleton, Oregon before attending Oregon State University for her undergraduate degree in Biology. After graduating, she began working at Oregon Health and Science University as an Electroencephalograph Technologist. She then went on to get her Master of Physician Assistant Studies degree, also at OHSU. Tauni is passionate about educating patients on the impact of lifestyle on health encouraging them to make healthy changes. Outside of work, she enjoys cooking, music, and anything active outdoors.

Rebecca Crowley-Huey, PA-C

Rebecca is new to the Pacific Northwest, from the Houston, Texas area. Rebecca resides with her physician husband and together they have seven children. Rebecca has a Physician Assistant Degree and has specialty in Family Medicine with experience in thyroid, diabetes, cholesterol management; Masters in Clinical Nutrition, along with 19 years of experience.

Christian Duren, MS, CDE, PA-C

Christian grew up in Texas in a 'military family' after leaving Germany when he was seven. Christian met his wife while they were both serving in the Navy during the Vietnam War. Following their discharges, he and his wife moved to West Virginia where they started their family and where Christian graduated from a Physician Assistant program in 1982. They both worked in Montana and then Oregon prior to returning to West Virginia where Christina obtained his Master's degree in 1995. Given that his interest is in diabetes management, he has maintained his certification as a Diabetes Educator since 1985 and has also taught PA students for a few years. Christian has resumed working as a PA in Oregon since 1998. Other than his profession, Christian pursues interests in backpacking, canoeing, bicycling, hiking and spending time with his family, which now includes three grandchildren.

At Willamette Valley Endocrinology, we specialize in treating diabetes, high cholesterol, obesity, thyroid disease, and other hormone and metabolism related problems. Each of our five providers are well trained to meet your individual medical needs.

*****Our Physician Assistants, for those who are less familiar with PAs, are medical professionals trained and licensed to practice medicine in collaboration with and under limited supervision from a physician. PAs take histories, conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel and educate, and write prescriptions. Having Physician Assistants in our practice allows patients to receive care sooner than would otherwise be possible. The PA-physician team has been known to enhance the coordination and quality of patient care.**

PATIENT INFORMATION

Today's Date: _____

Last Name: _____First Name: _____Middle Name: _____
Birthdate: _____Age:_____Gender:_____
Mailing Address: _____Email:_____
City: _____State:_____Zip:_____
Day Phone: _____Evening Phone: _____Cell Phone: _____
Preferred Contact Phone Number? _____

Race: (Circle One)
American Indian or Alaska Native Asian Black or African American Caucasian

Hispanic Multi-Racial Native Hawaiian or Other Pacific Islander Unknown Decline

Ethnicity: (Circle One)
Hispanic or Latino Not Hispanic or Latino Unknown Decline

Language:_____

Occupation: _____ Employer: _____
Work Address: _____City:_____State:_____Zip:_____
Business Phone: _____

Primary Care Physician (Include first and Last Name) _____
Referring Physician (Include First and Last Name) _____

Spouse or Parent's Name: _____
Address: _____

PRIMARY INSURANCE_____INSURED NAME_____

ID#_____GROUP#_____

SECONDARY INSURANCE_____INSURED NAME_____

ID#_____GROUP#_____

CREDIT POLICY: All charges are to be paid in full within 90 days UNLESS ARRANGEMENTS HAVE BEEN MADE AND A PAYMENT PLAN HAS BEEN ESTABLISHED. It is important that a payment is made each month. Past due accounts may be referred to a collection agency. I understand that if this becomes necessary to use a collection agency, that I may be charged any or all collection costs at the time my account is assigned.
I understand that there are some services that may not be approved or are not covered under my particular medical plan. I am agreeing to pay for all services personally if they are not covered by my insurance.

SIGNATURE_____**DATE**_____
PRINT NAME: _____

Medical Information Release Form
(HIPAA Release Form)

Name: _____ Date of Birth: _____

Release of Information

[ ] Please list family or friends we have your permission to speak with regarding your medical condition and care. **Please include name and phone number.**

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____
If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signature: _____ Date: _____

Print Name: _____

NEW PATIENT HEALTH QUESTIONNAIRE

What is your health concern at this time and what is the reason for your visit?

_____
_____

List all prescription and non-prescription medications you take.
Patients with Diabetes: List the glucometer brand, test strip brand, and how many times you check your blood sugar in a day, if you use a pen or vial.
If you do not take any medications, write none.

****FOR PRESCRIPTION REFILLS CALL YOUR PHARMACY FIRST****

Medication: Strength: Dose:

_____
_____
_____
_____
_____
_____

****FOR PRESCRIPTION REFILLS CALL YOUR PHARMACY FIRST****

Pharmacy with location: _____

Are you allergic to any medications: YES NO
If yes, name drugs and describe reaction: _____
_____
_____

Medical History: List **all** past **surgeries**, **hospitalizations** and **illnesses**.
If none, write none.

Problem: Date: Problem: Date:

_____
_____
_____
_____
_____
_____
_____
_____
_____

If applicable, date of last:
DEXA_____ Mammogram_____ Colonoscopy_____

Health Maintenance:
Have you received your annual flu vaccination? YES NO
Date of last tetanus vaccination: _____ _____
Date of last Pneumovax (pneumonia) vaccination, if applicable: _____

SIGNATURE_____DATE_____
PRINT NAME: _____

Family Health: If there are no health problems, write none for which it applies to the family member. If health problem is not known for specific family member, write unknown. Under other family members list whether family member is **maternal or paternal. Names are not needed.**

List all health problems of your **blood-related family members**, along with age and cause of death. Specifically mention a history of diabetes, cancer (type), heart disease including strokes, lung disease, thyroid disease, depression or alcoholism.

Father: □ living □ deceased. Age: ___
Medical Condition: _____
_____

Mother: □ living □ deceased. Age: ___
Medical Condition: _____
_____

Sister(s): □ living □ deceased. Age(s): ___
Medical Condition: _____
_____

Brother(s): □ living □ deceased. Age(s): ____
Medical Condition: _____
_____

Son(s): □ living □ deceased. Age(s): __
Medical Condition: _____
_____

Daughter(s): □ living □ deceased. Age(s): __
Medical Condition: _____
_____

Other family member(s) Maternal or Paternal: □ living □ deceased. Age(s): ____
Medical Condition: _____
_____

Other family member(s) Maternal or Paternal: □ living □ deceased. Age(s): ____
Medical Condition: _____
_____

SIGNATURE_____DATE_____
PRINT NAME: _____

Social History:

Usual Occupation (work done most of life):_____

Marital Status: Married Divorced Separated Widowed Single

Who lives in your household (name, relationship, age):_____
_____

Children: YES NO Number of sons: _____ Number of daughters: _____

Use of Tobacco: YES NO FORMER SECOND-HAND
Type (circle): Chewing Cigar Cigarettes Pipe Other:_____
Amount (can/pack) per day/week/month: _____ Number of years: _____Year Quit: _____

Use of Alcohol: YES NO FORMER
Type (circle): Beer Wine Liquor Hard Liquor Methanol Other: _____
Amount (glass/bottle/can) per day/week/month: _____Year quit: _____

Use of Caffeine: YES NO
Type (circle): Coffee Soda Tea Tablets Energy drinks Chocolate Other: _____
Amount (can/oz/cup) per day/week/month: _____

Do you exercise regularly? YES NO
If yes, what exercises? _____
How many days per week? _____ How many hours per week? _____

Animals in the home: YES NO Circle: Dog Cat Bird Other (please specify):_____

Circle the items found in your home:
FIREARMS SMOKE DETECTOR FIRE EXTINGUISHERS CARBON-MONOXIDE DETECTOR

Do you use seatbelts? YES NO

Optional to answer: Do you have a religious affiliation? _____ Religion: _____
Would you like spiritual information for combating stress, depression, drug abuse or other problems? YES NO

SIGNATURE_____ DATE_____
PRINT NAME: _____

Review of Systems: Circle/comment on new or recent changes in your personal health:

1. Chills, fever, or night sweats? _____
2. Recent change in weight? _____
3. Change in vision, smell or hearing loss? _____
4. Nasal congestion or drainage? _____
5. Voice change, difficulty swallowing or hoarseness? _____
6. Shortness of breath, cough or wheezing? _____
7. Exposure to tuberculosis? _____
8. Chest pain, swelling in the feet or ankles, irregular heart beat? _____
9. Numbness, tingling, pain or varicose veins in the lower extremities? _____
10. Constipation, diarrhea, or blood in the stool? _____
11. Nausea, vomiting, reflux or heartburn? _____
12. Pain with urination, frequent urination or waking during the night to urinate, blood in the urine, urgency or urinary incontinence? _____
13. Headaches, dizziness, light-headedness, tremors, difficulty walking or recent loss of consciousness? _____
14. Difficulty concentrating, difficulty sleeping, or frequent snoring? _____
15. Changes in skin, rashes or acne, or nail changes? _____
16. Food allergies, bee sting allergies, asthma or hay fever? _____
17. Any sexual problems you wish to discuss? _____
18. Any extra hair growth or unusual hair loss? _____
19. Muscle, back, bone or joint pain? _____
20. Swollen lymph nodes, easy bleeding or bruising? _____

Women only:

1. Date of last menstrual cycle: _____
2. Menstrual cycles: Regular or Irregular? _____
3. Do you perform regular breast self-exams? _____
4. Current form of birth control, if applicable: _____
5. Any breast discharge or lumps? _____
6. Have you ever used any type of hormone replacement? _____

SIGNATURE_____ **DATE**_____
PRINT NAME: _____

Steps to refill prescription(s):

Your name, medication (name, strength, and dose), prescription number and prescribing Doctor, number of refills can all be found on your prescription bottle.

1. Call pharmacy phone number on your prescription bottle. Some local pharmacies and mail order pharmacies provide the option of requesting refills online.
2. Go through the prompts and options. Supply prescription number when prompted.
3. Refill should be completed in 2 business days. Call your pharmacy for the status of the refill.
4. Pharmacy will contact prescribing doctor for refills.

If there are any issues with the pharmacy not getting a prescription refilled, please contact the prescribing Doctor's office.

700 BELLEVUE S.E., SUITE 240
SALEM, OREGON 97301

WILLAMETTE VALLEY ENDOCRINOLOGY
PHYSICIAN AND P.A.'s of
ENDOCRINOLOGY AND METABOLISM

TELEPHONE (503) 399-8105
FAX (503) 581-5351

MISSED/CANCELLED APPOINTMENT POLICY

Effective May 1, 2005
Revised May 14, 2013

It is our office policy to do all we can to help our patients make it to their appointment. As a **courtesy**, we try our best to call and confirm patient appointments. We make every effort to verbally confirm your appointment and get a commitment from you, the patient or the responsible party to make your scheduled appointment. Missed/cancelled appointments still occur and this is lost time for our office as well as other patients waiting for an appointment.

The Oregon Medical Board, states that there are NO rules or regulations in writing that prohibit us from charging the full office visit price for no shows. However, our office will only charge a $75.00 fee for no shows or cancellations if you have not given a **seventy-two (72) hour business day notice** of the cancellation. The amount of **$75.00** will be billed directly to you, and this amount is **NOT** covered by insurance.

Multiple missed/cancelled appointments confirm to our office that the patient/doctor relationship is not working. Therefore, after three (3) missed appointments for established patients or two (2) missed/cancelled appointments for new patients, our missed/cancelled appointment policy allows your doctor to terminate your care. If your doctor terminates care with you, a letter will be sent giving you thirty (30) day written notice and will no longer be responsible for your care after that thirty (30) day period.

Please make every effort to contact us at least **seventy-two (72) hours** (3 business days) in advance if you are unable to keep your scheduled appointment. Our answering service is available twenty-four (24) hours a day to take those cancellations at (503) 399-8105. When cancelling through our answering service, please make sure you give the operator the patient's name, the provider with whom they are scheduled, and reason for cancellation.

Note: We do realize that emergencies and serious sicknesses occur, each will be considered case by case.

Thank you for your cooperation,
Martin L. Bassett, M.D., P.C.

700 BELLEVUE S.E., SUITE 240
SALEM, OREGON 97301

WILLAMETTE VALLEY ENDOCRINOLOGY
PHYSICIAN AND P.A.'s of
ENDOCRINOLOGY AND METABOLISM

TELEPHONE (503) 399-8105
FAX (503) 581-5351

MISSED/CANCELLED APPOINTMENT POLICY

I have read and understand the missed/cancelled appointment policy. I agree to give a **72-hour notice** (business days) if I have to cancel my appointment or I will receive a **$75.00 missed/cancelled appointment fee**. By not signing this document does not invalidate our office policy.

SIGNATURE_____DATE_____
PRINT NAME: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to Sign This Acknowledgement

I have read the copy of this office's Notice of Privacy Practices and have been advised I may receive a copy of it at my request.

SIGNATURE_____DATE_____
PRINT NAME: _____

Preauthorization

Due to the fact that our providers are specialist, a pre-authorization from your insurance may be required. Therefore, it is the patient's responsibility to call their insurance and make sure authorizations have been made, and are **dated for each and every visit with their provider.** Otherwise it will be the patient's responsibility for making the payment.

Thank you,
Betty Olsen
Office Manager

I have read the above and understand that it is my responsibility to check with my insurance and make sure any pre-authorization, for each visit, is required.

SIGNATURE_____DATE_____
PRINT NAME: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining
_____Other (Please Specify)

Dear Valued Patient,

We look forward to meeting you and having the opportunity to treat you as a patient. Due to the time needed to enter correct medical information for you into our electronic medical records we are now going to require that your New Patient Packet be completed and returned to us within two (2) business days.

By receiving your information early, your appointment time can be spent more effectively with the provider. We understand the importance of your consultation with us and want to ensure that your medical needs are addressed during the appointment, rather than time being spent entering your information.

Thank you.

Sincerely,

Martin Bassett, MD

How to get to Willamette Valley Endocrinology

Willamette Valley Endocrinology is on the 2nd floor of the Northbank Plaza. The Plaza is located on a cul-de-sac at the end of Bellevue Street off Church Street. Church Street is accessible by Trade Street or Mission Street.

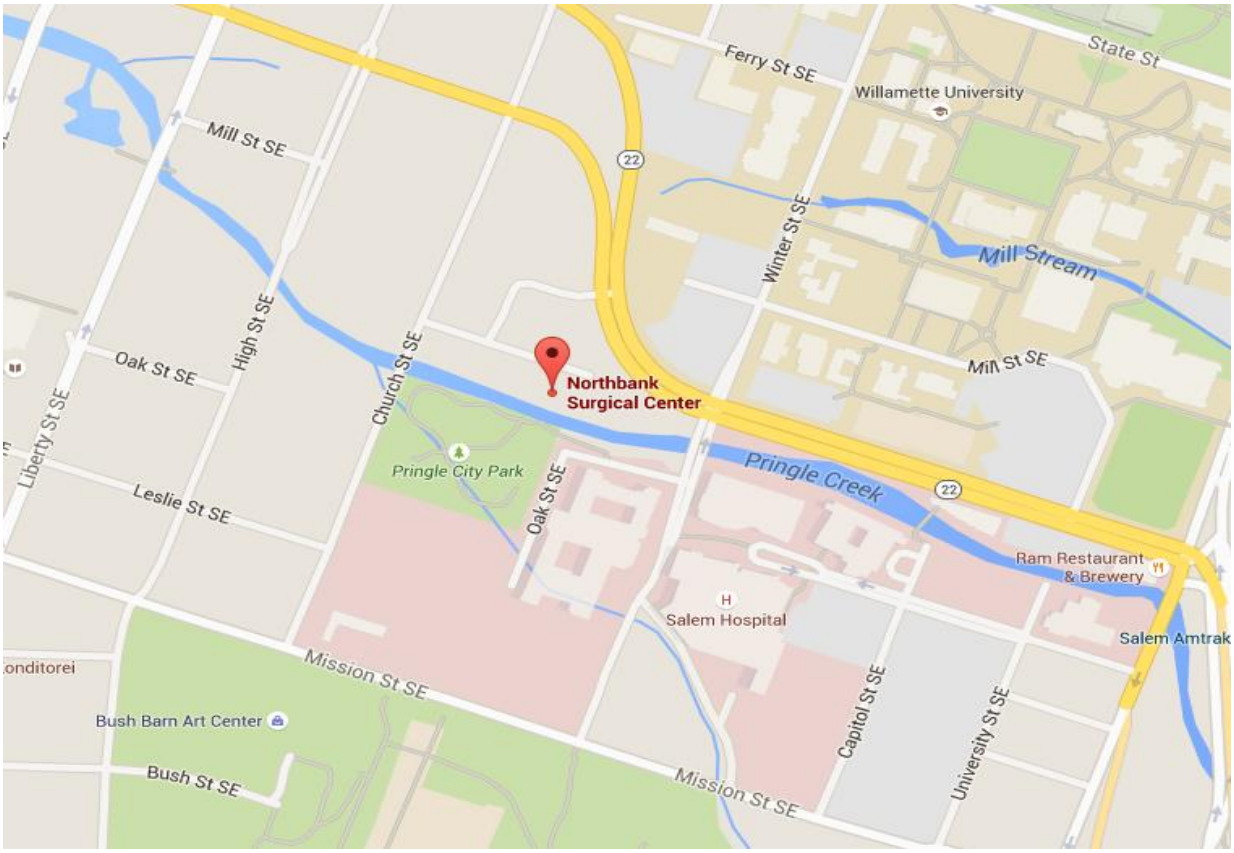
The Parking Lot is on your right as you approach the Plaza building. Turn right and park facing the creek. It is ok to park in any space marked “visitor”.

Enter the building through the front door from the sidewalk.

Take elevator or stairs to the 2nd floor and go down the hall to your right to #240.

(SEE MAP ON FOLLOWING PAGE)

PLEASE NOTE: GPS will not take you to 700 Bellevue Street, but instead to the continuation of Bellevue Street. Please follow the map and instructions below.



Heading South on I-5.

- Take **Exit 253** to **Hwy 22/99E/Mission St SE** and turn **right**.
- Continue on **Mission St** to **Church St SE**.
- Turn right on **Church St SE**.
- Continue on **Church St** to first **right** at **Bellevue St SE** and turn **right**.
- Go down to end of cul-de-sac to **Northbank Plaza**.

Heading North on I-5.

- Take **Exit 253** to **Hwy 22/99E/Mission St SE** and turn **left**.
- Continue on **Mission St** to **Church St SE**.
- Turn right on **Church St SE**.
- Continue on **Church St** to first **right** at **Bellevue St SE** and turn **right**.
- Go down to end of cul-de-sac to **Northbank Plaza**.

From West Salem - Wallace Road

- Merge onto **OR-22 E/Center St Bridge** via the ramp to **Salem**.
- Merge onto **OR-22 E/OR-99E BUS S/Front St NE** via the ramp to **Albany**.
- Turn **left** at **Trade St SE**.
- Turn **right** at **Church St SE**.
- Take the 1st **left** onto **Bellevue St SE**

NOTICE OF PRIVACY PRACTICES

Benjamin R. Wilson M.D. / Martin L. Bassett M.D., P.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about or privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect 04/14/2003 and will remain in effect until we replace or modify it.

We reserve the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy process please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals evaluating practitioner and provider performance conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorizations when it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights Section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable interests of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to overt a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces responsible under certain circumstances. We may disclose to authorize federal government information required for lawful intelligence, counterintelligence, and other national security advocates. WE may disclose to a correctional institution or law

Enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with information regarding medical appointments (such as voicemail messages, answering machine or family members).

PATIENT RIGHTS

Access: You have the right to look at, or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a minimal fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates or we disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive on our Website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

BENJAMIN R. WILSON M.D. / MARTIN L. BASSETT M.D., P.C.