Willamette Valley Endocrinology

MARTIN L. BASSETT, M.D., P.C.

925 COMMERCIAL ST. S.E., SUITE 320
SALEM, OREGON 97302

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

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

Dear ______________________________, You are scheduled for a consultation in our office with

☐ Martin Bassett, MD ☐ Tauni Carter, PA-C ☐ Christopher Killen, PA-C
☐ Katherine Zuber, PA-C ☐ Joshua Gratwohl, PA-C

on ________________ at ________ am/pm. Please **check-in at_______ am/pm.**

Please bring this packet to your appointment completed, along with your insurance card(s) and photo ID.

If you are not able to make this appointment, call our office 72 hours (3 days) in advance, prior to your appointment to avoid a $75 late cancel/no show charge.

PLEASE NOTE: COPAYS are DUE at the time of service.

Directions:

Heading SOUTH on I-5

- Take Exit 253 to Hwy 22/99E/Mission St SE and turn right.
- Continue on Mission St. to Commercial St
- Turn left on Commercial St SE. from the right turn lane
- After one block, turn right into parking lot at 925 Commercial St SE immediately after Kearney St. S.

From West Salem – Wallace Rd.

- Merge onto OR-22/Center St Bridge via the ramp to Salem
- Merge onto the south bound ramp labeled OR-22E/ORE BUS S/Albany which takes you onto Front St.
- Stay in the right lane to turn right onto Commercial St SE
- Continue south to 925 Commercial St SE, Ste. 320 taking the first right into parking lot immediately after Kearney St S.

Heading NORTH on I-5

- Take Exit 253 to Hwy 22/99E/Mission St SE and turn left.
- Continue on Mission St. to Commercial St SE
- Turn left on Commercial St SE. from the right turn lane
- After one block, turn right into parking lot at 925 Commercial St SE immediately after Kearney St. S.

From East of Salem on Highway 22 East

- Follow Highway 22 into Salem where it becomes Mission St.
- Continue on Mission St. to Commercial St. SE
- Turn left on Commercial St SE. from the right turn lane
- After one block, turn right into parking lot at 925 Commercial St SE immediately after Kearney St.

Demographics

Name: ________________________ **DOB:** ______________ **SSN#:** ________________

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Address: ____

Cell #: ____________ **Home #:** ____________ **Work #**____________

Would you like text or call appointment notifications? ____________

E-mail: ____________________

Employer: ____________________

Sex: ________ **Marital Status:** ____________ **Race:** ____________

Religious Affiliation (optional): ____________________

Emergency Contact Name and Phone number: ____________________________

Primary Care Provider Name & Location: ____________________________

Primary Insurance Company: ________________ **Member ID:** ____________

Group #: ____________ **Effective Date:** ______ **Subscriber:** ____________

Secondary Insurance Company: ________________ **Member ID:** ____________

Group #: ____________ **Effective Date:** ______ **Subscriber:** ____________

Are you currently seeing other specialists? (neurology, cardio, nephrology, ophthalmology)

Provider Name: ________________ **Specialty:** ________________

Location: ____

Provider Name: ________________ **Specialty:** ________________

Location: ____

Provider Name: ________________ **Specialty:** ________________

Location: ____

New Patient Health Questionnaire

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

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____

____

List all prescription and non-prescription medications you take. If you do not take any medications, write none.

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.

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

Medication Name	Dosage	Frequency
EXAMPLE	20MG TABLET	1 TABLET DAILY

Preferred pharmacy with location and telephone if known: ________________________________

Are you allergic to any medications: ☐YES ☐NO

Medication	Reaction

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

Type: Surgery? Diagnosis?	Date:	Type: Surgery? Diagnosis?	Date:

If applicable, date of last: DEXA__________________ Mammogram_________________ Colonoscopy______________

Review of Systems

Circle New or Recent Changes and Explain

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1. Chills, fever, fatigue, night sweats?
2. Constipation, diarrhea, blood in stool?
3. Rashes, acne, nail changes?
4. Changes in: Vision, smell, or hearing?
5. Voice change, difficulty swallowing, hoarseness?
6. Shortness of breath, cough ,wheezing?
7. Difficulty concentrating, insomnia, frequent snoring?
8. Urinary incontinence, dysuria, nocturia, blood in urine, urinary urgency?
9. Unexplained changes in weight?
10. Nausea, vomiting, reflux, heartburn?
11. Unexplained Hair changes?
12. Nasal congestion or drainage?
13. Muscle pain, bone pain, joint pain?
14. Chest pain, swelling at ankle or feet, irregular heartbeat?
15. Headaches, dizziness, light-headedness, tremors?
16. Difficulty walking or loss of consciousness?

Women only:

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

Lifestyle History

Use of Tobacco: ☐YES ☐NO ☐FORMER ☐SECOND-HAND

Type (circle): Chewing Cigar Cigarettes Pipe Vape 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 **Amount** (can/oz/cup) per day/week/month: _________________

Type (circle): Coffee Soda Tea Tablets Energy Drinks Chocolate Other: __________

Do you exercise regularly? ☐YES ☐NO

If yes, what exercises? ____

How many days per week? __________________________ How many hours per week? ________________________

Optional: Would you like spiritual information for combating stress, depression, drug abuse or other problems? ☐YES☐NO

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Family Health

List all health problems of your **blood-related family members**, along with age and cause of death. Specifically mention any history of diabetes, cancer (type), heart disease including strokes, lung disease, thyroid disease, depression, or alcoholism.
If there are no health problems, write none for which it applies to the family member. If a health problem is not known for specific family member, write unknown. Under other family members please circle **maternal or paternal. Names are not needed.**

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: ____
____

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

Children: YES NO Number of sons: ______________ Number of daughters: _________________

Other children (step or other):__________________ Total number of persons living in household:______________________

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Medical Information Release Form

Name: ____ Date of Birth: _________________

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

[ ] Spouse____

[ ] Child(ren) ____

[ ] Other____

[ ] Information is not to be released to anyone.

Voice 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

Patient Portal

I would like to enroll in the patient portal: [ ] yes [ ] no

If yes, please provide email: ____

I would like a parent or family member to have access to your patient portal? [ ] yes [ ] no

If yes, please provide their Name: ________________________, Email _____________________________,
& Date of Birth __________________________

What kind of access:

[ ] Limited (able to send in messages and refill request)

[ ] Full (access to all medical records and features)

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

Signature: ____ Date: _____________

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FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Willamette Valley Endocrinology for your care. We appreciate the opportunity to serve your health care needs and look forward to getting to know you. If you have any questions or concerns, please feel free to discuss these with our staff. We provide personalized, high-quality healthcare in the most cost-effective manner. This form was developed to explain and clarify our financial policies. Please read this carefully and sign where indicated. Your signature indicates that you have read and understood our policies and that you will honor the terms. We appreciate your cooperation.

Standard Payment Policy: Co-pays for office visits are due at the time services are rendered or the appointment will be rescheduled. We may require that you make a deposit towards your office visit if you have a high deductible. For your convenience, we accept Mastercard, Visa, American Express, checks, and cash. For Medicare patients, our office accepts assignment and files claims with Medicare. Medicare patients are responsible for any coinsurance and deductible amounts. Medicare patients must present their Medicare card at the time of registration. We do file secondary insurance for Medicare patients. If you are an HMP/PPO (manage care) patient of a plan in which we participate, our office has agreed to accept the plan's fee schedule and file the claim with your insurance company. HMO/PPO patients are responsible for co-pays and deductibles at the time of service or appointment will be rescheduled. HMO/PPO patients must present their insurance card at the time of registration. HMO/PPO patients are responsible for obtaining a referral number from your primary care physician.

Payment Policy: We file insurance claims for all patients and inform you of estimated deductibles and co-insurance amounts for exams. You will be billed for any remaining balance once insurance has paid its portion, which is due upon receipt.

Assignment of Benefits: All medical insurance benefits are paid directly to Willamette Valley Endocrinology. You are financially responsible for all the charges whether or not paid by insurance. This form authorizes Willamette Valley Endocrinology to release all information necessary to secure the payment of benefits.

Insurance Claims: We make every effort to seek insurance reimbursement on covered services. Filing insurance is a service we provide to you; however, insurance is a contract between you and your carrier. Once your insurance company has paid, you will receive a bill for any remaining balance on the account, which is due upon receipt.

Collection Efforts: All balances must be paid in full within 90 days of the date of service to avoid collection agency. We work with you to make payment arrangements so that any balance is paid within the previously stated 90-day timeline. If these efforts do not result in a resolution of the account, the account may be referred to a collection agency and the local credit bureau. Any collection fees incurred by our office are charged to your account. All patient balances are due prior to their next appointment or it will be rescheduled. Should you need prescription refills and they have been discontinued due to a delinquency on your account (which will happen 60 days after 1st notification) you will need to speak to your referring provider.

Returned Checks: A service fee of $20.00 is charged on all returned checks. You will be afforded the opportunity to remit the total of the check plus the $20.00 fee in the form of cash, cashier's check, or money order on a timely basis.

Missed or Cancelled Appointments: As a courtesy we offer enrollment in our auto appointment reminders. It is the patient's responsibility to manage their appointments. If you do not appear for your appointment or cancel your appointment in less than 72 hours in advance, you could be charged a $75.00 "no-show" fee. We do take into consideration emergencies for our patients. See attached "no show and late cancel policy". Willamette Valley Endocrinology reserves the right to acknowledge and dismiss any patient due to continued noncompliant behavior such as disregarding healthcare instructions given by patient's provider or any harmful or disrespectful behavior to provider or staff.