Patient Agreement

Notice of Privacy Practice Acknowledgement

I acknowledge that I received a copy of Notice Privacy Practices. By Signing below, I agree that I have received or have been offered a copy of the notice of Privacy Practices.

Financial Policy Acknowledgement

By signing below, I agree to the financial policy for Portland Hand Clinic, P.C.
I hereby authorize Portland Hand Clinic, P.C. or the representative to submit a claim to my insurance carrier or its intermediaries for all services rendered and direct my insurance carrier or its intermediaries to issue payment directly to Portland Hand Clinic, P.C. I authorize release of all information that is pertinent to my insurance company.
I understand I am responsible for all charges not covered by my insurance company. Please note that accounts not paid within 90 days are considered delinquent.
Waiver: I understand that in order to cover my services a referral from my primary care physician may be necessary. If Portland Hand Clinic does not receive written authorization or referral from my primary care physician, I will be held financially responsible for any and all charges incurred.

EFFECTIVE 4/14/25: PORTLAND HAND CLINIC, P.C. RESERVES THE RIGHT TO CHARGE $25 PER FMLA, PAID LEAVE, OR SHORT TERM DISABILITY FORM. THIS AMOUNT MUST BE PAID IN FULL AFTER FORMS ARE COMPLETED AND BEFORE FORMS ARE HANDED BACK TO PATIENTS OR FAXED TO THEIR DESTINATION. THIS INCLUDES ANY FORM REVISIONS OR CHANGES TO ORIGINAL FORMS.

Assignment of Benefits

I hereby assign all medical and surgical benefits , to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Portland Hand Clinic, P.C., medical services rendered to myself and/or my dependents regardless of my insurance benefits if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Portland Hand Clinic, P.C. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims in the course of examination or treatment; and (3) allow a photocopy of my signature.

Medication History Download

I understand and give my consent to retrieve and review my medication history. I understand that this will become part of my medical record. A medication history is a list of medicines that these providers and other healthcare providers have recently prescribed for a patient. It is collected from a variety of sources, including a patient's pharmacy.

Acknowledgement of Receipt of Notice of Privacy The Portland Hand Clinic

We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Portland Hand Clinic, P.C. identifies all potential uses and disclosures of your health information by Portland Hand Clinic outlines your rights with regard to your health information. Please acknowledge that you have received our Notice of Privacy Portland Hand Clinic, P.C.

Consent to Call

Entry of telephone number constitutes written consent for Portland Hand Clinic, P.C. Entities to send automated, prerecorded, and artificial voice telephone calls to that telephone number. To alter or revoke this consent, visit patient Portal “Contact Preferences” Page.

Patient Authorization to Receive/ Release Medical Records

I authorize Portland Hand Clinic, P.C. to send/ receive the following information

- The last 3 visit notes to any tests/labs/imaging reports/ekgs performed in the last 6-12 months
- All records, labs, pathology reports and diagnostic imaging reports
- Abstract/summary
- Other associated information

These records may contain information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted diseases, you are here by authorizing disclosure of this information.

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3 No Call No Show Policy

To ensure availability for all patients, **Three seperate** no-call, no-show appointments may result in termination of care from our practice.

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Patient Signature

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Patient Name Printed

_____

Date

Portland Hand Clinic, P.C.
2306 SE Cesar E Chavez Blvd, Portland, OR 97214
Phone (503) 239-8430