WELCOME!

It is our pleasure to welcome your family to Metropolitan Pediatrics!

We are very excited that you have chosen us, and can't wait to get-to-know you, your care preferences, and health goals… **so we can care for your family like no one else!**

HOME SWEET MEDICAL HOME

During your visit, we want you to feel welcome, cared for, and respected… just like you do in your own home! That's why we make it easy and comfortable for you to get the care you need, in the way that works best for your family.

As your Medical Home, we will:

- ♥ Listen to you and answer your questions.
- ♥ Connect you to care, information, and services to keep you healthy.
- ♥ Encourage you to have an active role in your own health.
- ♥ Help and support you in any way we can!

In return, we ask that you get involved in your care, team up with us to meet your health goals, and let us know when you have questions or concerns.

Immunizations are an essential part of well child care. Metropolitan Pediatrics follows the national immunization guidelines set forth by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the Centers for Disease Control, and the American Academy of Family Physicians.

APPOINTMENTS

We are open 7 days a week to serve you! Hours vary by location. We do our best to accommodate same-day appointments. Call early as openings tend to fill quickly.

Well Care
Please schedule check-ups 1 to 2 months in advance, so you can reserve a time that works best with your schedule.

Cancellations
We ask that you kindly give us 24-hour notice when canceling or rescheduling appointments.

Preparation

At the time of your visit, you will be asked to present the following:

- ❑ Copay, if applicable
- ❑ Enclosed forms, completed
- ❑ Health insurance card(s)
- ❑ Photo ID
- ❑ Current medications, including dosage and strength
- ❑ Current immunization records
- ❑ Previous medical records, or arrange for your previous physician to send records

24/7 ADVICE & SUPPORT

During business hours, we are happy to answer general questions over the phone. Urgent matters will be addressed before the day is over. For less urgent matters, we will return your call within 24-48 hours.

For after-hours advice, we offer a live answering service that can assist you, or connect you with on-call advice for guidance.

Reach Advice anytime, day or night, by calling your clinic's daytime phone number.

WEEKEND CARE

Appointments are available for both check-ups and sick/injury visits. Well visits are scheduled with your primary care provider. Call as early as 8:00am to reserve an appointment.

Please contact us before going to an urgent care clinic or the ER! In most cases, we can treat your child in our clinic, saving you time and worry.

GRESHAM

25050 SE Stark Street
Suite 300
Gresham, OR 97030
503.667.8878

Monday-Friday
OPEN: 7:30am – 5:30pm
Call us: 7:30am – 5:30pm

Saturday
OPEN: 10:00am – 12:00pm
Call us: 8:00am – 12:00pm

Sunday
CLOSED: Care at Happy Valley
Call us: 8:00am – 12:00pm

HAPPY VALLEY

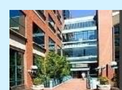
9300 SE 91st Avenue
Suite 200
Happy Valley, OR 97086
503.261.1171

Monday-Friday
OPEN: 8:30am – 5:30pm
Call us: 7:30am – 5:30pm

Saturday
CLOSED: Care at Gresham
Call us: 8:00am – 12:00pm

Sunday
OPEN: 10:00am – 12:00pm
Call us: 8:00am – 12:00pm

NORTHWEST



1130 NW 22nd Avenue
Suite 320
Portland, OR 97210
503.295.2546

Monday-Friday
OPEN: 8:30am – 5:30pm
Call us: 7:30am – 5:30pm

Saturday
OPEN: 10:00am – 12:00pm
Call us: 8:00am – 12:00pm

Sunday
OPEN: 10:00am – 12:00pm
Call us: 8:00am – 12:00pm

WESTSIDE

15455 NW Greenbrier
Parkway, Suite 111
Beaverton, OR 97006
503.531.3434

Monday-Friday
OPEN: 8:00am – 7:00pm
Call us: 7:30am – 6:30pm

Saturday
OPEN: 9:00am – 3:00pm
Call us: 8:00am – 2:30pm

Sunday
OPEN: 9:00am – 1:00pm
Call us: 8:30am – 12:30pm

Authorization to Release Medical Records

Patient records are available on Epic's Care Everywhere Network via Legacy and also by fax, secure email, or mail.

Send Records / Record Requests / Revocation Requests to ⇨ Metropolitan Pediatrics – Health Information Services Department:
15455 NW Greenbrier Parkway, Suite 112 • Beaverton, OR 97006 • 503-601-3417 • F 503-466-1858 • HIS@metropediatrics.com

Patient Name: ________________________ Date of Birth: ____/____/____ Phone: (_____) ____________

Address: ____
Street City State Zip Code

I Authorize My Health Information to Be:

❑ Sent to:
❑ Requested from:
❑ Verbally exchanged with:
❑ **I don't need records at this time.**

Name: ____________________

Address: ____________________

City/State/Zip: ____________________

Phone: (_____)__________ Fax: (_____)__________

Email: ____________________

My health information: ❑ MAY or ❑ MAY NOT be faxed.
❑ MAY or ❑ MAY NOT be securely emailed.

Purpose of Release:

❑ Changing Physician/Clinic*

❑ Personal Use**

❑ Legal

❑ Other: ____________

*Records sent to outside physicians/clinics are provided free of charge.

**There is a flat copy charge of $20.00 for any personal request for medical records. Please make checks payable to: Metropolitan Pediatrics. Your request will be processed within 30 days.

Indicate Type of Information to Be Released Below:

❑ **General Medical Records**
excluding protected records. Copies of medical records will be limited to two (2) years of information including progress notes, lab and x-ray reports, and immunizations.

–OR–

Specific Information Only:

❑ All Medical Records — Specify Date(s): ____________
❑ Medications
❑ Lab, Pathology, EKG — Specify Type/Date: ____________
❑ X-ray Reports
❑ Immunizations Only
❑ Other — Please Specify: ____________

Protected or Sensitive Information:

I understand that certain information cannot be released without specific authorization as required by State/Federal law. By INITIALING, I authorize the release of the following protected or sensitive information. **Patients 14+ must provide initial.**

_______ (initial) DRUG & ALCOHOL DIAGNOSIS/TREATMENT
_______ (initial) ADD/MENTAL HEALTH TREATMENT
_______ (initial) AIDS/HIV TEST RESULTS including related high risk behavior
_______ (initial) GENETIC TESTING

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

You are under no obligation to sign this form, and you may refuse to do so. Treatment, payment, enrollment, or eligibility benefits may not be conditioned on signing this authorization, with the exception of obtaining information in connection with eligibility or enrollment in a health plan.

You have the right to revoke this authorization at any time by providing a written request for revocation to Metropolitan Pediatrics' Health Information Services Department. If you revoke the authorization, the revocation will not affect any disclosures that were made prior to processing the revocation request. Unless otherwise revoked, this authorization will expire 1 year from the date signed or will expire on the following date, event, or condition: ____________.

X____________________ ____________________ X____/____/____
Signature of Parent or Legally Responsible Person | Print Name | Relationship | Date

X____________________ ____________________ X____/____/____
Signature of Patient 14+ years – REQUIRED | Print Name | Date

INTERNAL USE ONLY

I have verified: ❑ Form is complete ❑ Identity of requester
❑ Relationship (if not patient) ❑ Payment received: / /

Employee Name: Date: / /

HIS USE ONLY

Patient Information Form

Gresham: 503-667-8878 **Happy Valley:** 503-261-1171
Northwest: 503-295-2546 **Westside:** 503-531-3434

Parent Information:

Name: ____
Last First MI
SSN: ____________________ DOB: ___/___/___ ❑ M ❑ F
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed
Address: ____
City/State/Zip: ____
Email: ____
Home: (_____)___________ Cell: (_____)______________
How did you hear about us? ______________________________

Other Parent Information:

Name: ____
Last First MI
SSN: ____________________ DOB: ___/___/___ ❑ M ❑ F
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed
Address: ____
City/State/Zip: ____
Email: ____
Home: (_____)___________ Cell: (_____)______________

Patient Information:

New Patient? ❑ Y ❑ N
Name: ____
Last First MI
SSN: ____________________ DOB: ___/___/___ ❑ M ❑ F

Other Children in Family:

Patient Here? ❑ Y ❑ N
Name: ____
Last First MI
SSN: ____________________ DOB: ___/___/___ ❑ M ❑ F

Patient Here? ❑ Y ❑ N
Name: ____
Last First MI
SSN: ____________________ DOB: ___/___/___ ❑ M ❑ F

Patient Here? ❑ Y ❑ N
Name: ____
Last First MI
SSN: ____________________ DOB: ___/___/___ ❑ M ❑ F

Emergency Contact (other than spouse):

Name: ____
Last First MI
Relationship to Patient: ______________________________
Home: (_____)___________ Cell: (_____) ______________

Billing Information:

❑ **Private Pay (no insurance)**
❑ **Insurance (primary)** Eff. Date: ___/___/___
Insurance Co: ____
Employer: ____
Policyholder: ______________________ DOB: ___/___/___
Policy#: ____
Group#: __________________ Copay: $______________

❑ **OHP (circle one):** FamilyCare | CareOregon | OMAP
❑ **Insurance (secondary)** Eff. Date: ___/___/___
Insurance Co: ____
Employer: ____
Policyholder: ______________________ DOB: ___/___/___
Policy#: ____
Group#: __________________ Copay: $______________

Consent for Treatment: I authorize the physicians and clinic personnel of Metropolitan Pediatrics, LLC, to conduct physical examinations and routine services, order and perform tests, and administer treatment deemed necessary by the examining physician. Should treatment be performed, the physician will fully inform me as to the nature of the procedure, the alternatives to treatment, and the risks involved. I will be given the opportunity to ask questions and have my questions answered. Should special procedures be indicated, I understand that the examining physician will discuss this with me and that additional consent(s) may be required.

Financial Responsibility: I understand that I am responsible for all charges resulting from treatment provided by Metropolitan Pediatrics, LLC, as well as any agency and/or legal fees incurred should my account be placed in a collection status. I agree to pay the balance due within 30 days of statement billing unless I have made other payment arrangements.

Assignment of Benefits: I authorize my insurance carrier(s) to remit payment of benefits for any claim to Metropolitan Pediatrics, LLC. I understand that any ineligible or non-covered expenses are my responsibility.

I assign Metropolitan Pediatrics, LLC, as an Authorized Representative to: (1) Submit any and all appeals when my insurance company denies me benefits to which I am entitled, (2) Submit any and all requests for benefit information from my insurance company, (3) Initiate formal complaints to any state or federal agency that has jurisdiction over my benefits, and (4) Release all medical information necessary to process my claims. I authorize any plan administrator or insurer to release any and all plan documents, insurance policy, and/or settlement information upon written request from Metropolitan Pediatrics, LLC. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare, and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original.

X______________________________ ____________________ ____________ X_____/_____/_____
Signature of Patient, Parent, or Legally Responsible Person | Print Name | Relationship | Date

Rev. 07/20/2016

Patient Intake Form

Patient Name: ______________________________ Date of Birth: _____/_____/_____

MR#: ______________________________ Date of Service: _____/_____/_____

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White (non-Hispanic)
- ❑ Other

Welcome to Metropolitan Pediatrics! Please take the time to fill out this form as accurately as possible so we can most appropriately address your child's health needs. Thank you!

Birth History – Pregnancy:

Did mother: Smoke? ❑ Yes ❑ No

Drink alcohol? ❑ Yes ❑ No

Use drugs/medications? ❑ Yes ❑ No

If yes, what kind(s)? ______________________________

____

Experience illness/complications? ❑ Yes ❑ No

If yes, what kind(s)? ______________________________

____

Birth History – Delivery/Newborn Period:

Delivery Type: ❑ Vaginal ❑ C-section

Gestational Age: __________ Birth Weight: __________

Date hepatitis B given: _____/_____/_____

Problems in newborn period: ______________________________

____

____

____

____

____

Patient Medical History:

- ❑ ADD/ADHD
- ❑ Allergies
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Cancer/Oncology
- ❑ Diabetes mellitus
- ❑ Eating disorder
- ❑ Eczema
- ❑ Headaches
- ❑ Hearing loss
- ❑ Heart murmur
- ❑ Immune deficiency
- ❑ Inflammatory bowel disease
- ❑ Jaundice
- ❑ Meningitis
- ❑ Otitis media
- ❑ Pneumonia
- ❑ Prematurity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle cell
- ❑ Strep throat (recurrent)
- ❑ Thyroid disease
- ❑ Tuberculosis
- ❑ UTI
- ❑ Varicella (chickenpox)
- ❑ Vision problems
- ❑ Other: ______________________________

____

____

Patient Surgical History:

- ❑ Adenoidectomy
- ❑ Appendectomy
- ❑ Circumcision
- ❑ Cleft lip
- ❑ Cleft palate
- ❑ Cosmetic Surgery
- ❑ C-section
- ❑ Fracture surgery
- ❑ Heart surgery
- ❑ Hernia repair
- ❑ Inguinal hernia
- ❑ Lymph node biopsy
- ❑ Tonsillectomy
- ❑ Ear tubes
- ❑ Umbilical hernia
- ❑ Undescended testicle surgery
- ❑ Other: ______________________________

____

____

MORE QUESTIONS ON THE BACK SIDE ⇨

Family History

Have any family members had the following conditions? Please mark an 'X' by each condition that applies.

Family Member Name:	Mother:	Father:	Sibling:	Sibling:	Maternal Gma:	Maternal Gpa:	Paternal Gma:	Paternal Gpa:	Other:
Date of Birth:	/ /	/ /	/ /	/ /					/ /
Lives with patient?									
No Known Problems									
Other	→								
ADHD									
Allergy-Severe									
Arthritis									
Asthma									
Birth Defects									
Bleeding Problem									
Clotting Disorder									
Depression									
Developmental Delay									
Diabetes									
Early Death									
Eczema									
Hearing Loss									
Heart Defect									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Obesity									
Rheumatologic Disease									
Seizures									
Substance Abuse									
Sudden Death									
Thyroid Disease									
Vision Loss									

List any other conditions (by family member):

Genetic Privacy Notice

Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

Metropolitan Pediatrics, LLC, is required by Oregon law to provide this notice to you regarding the use of your health information or biological samples for genetic research (OAR 333-025-0100-333-025-0165). State law protects the genetic privacy of individuals and gives you the right to decline to have your health information or biological samples used for research.

A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect either the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or better treat heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. The team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, such as your name, Social Security number, or medical record number cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample, making it very difficult to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

If you DO NOT want to have your health information and biological sample available for anonymous or coded genetic research, YOU MUST tell your health care provider by checking the box below, signing, and returning the form as directed by your clinic representative.

Genetic Privacy Opt Out Statement:

❑ I have read and understand the above Genetic Privacy Notice, and I DO NOT want to have my health information and biological samples available for anonymous or coded genetic research.

If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, please sign and return this form without checking the opt out box. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

No matter what you decide now, you can always change your mind later by completing this form and returning it to your health care provider. Your new decision is effective on the date your health care provider receives the Genetic Privacy Opt Out, and will apply only to health information or biological samples collected after your health care provider receives the form. If you have questions about Genetic Testing, please call the Oregon Genetics Program at 971-673-0271.

This form will be retained in your medical chart throughout your relationship with Metropolitan Pediatrics, LLC.

Patient Name (PRINT): ______________________________ Patient DOB: _____/_____/_____

X________________________________ ________________________ X_____/_____/_____

Signature of Patient or Legally Responsible Person | Relationship to Patient | Date