Lane Community College

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Lane Community College Health Clinic

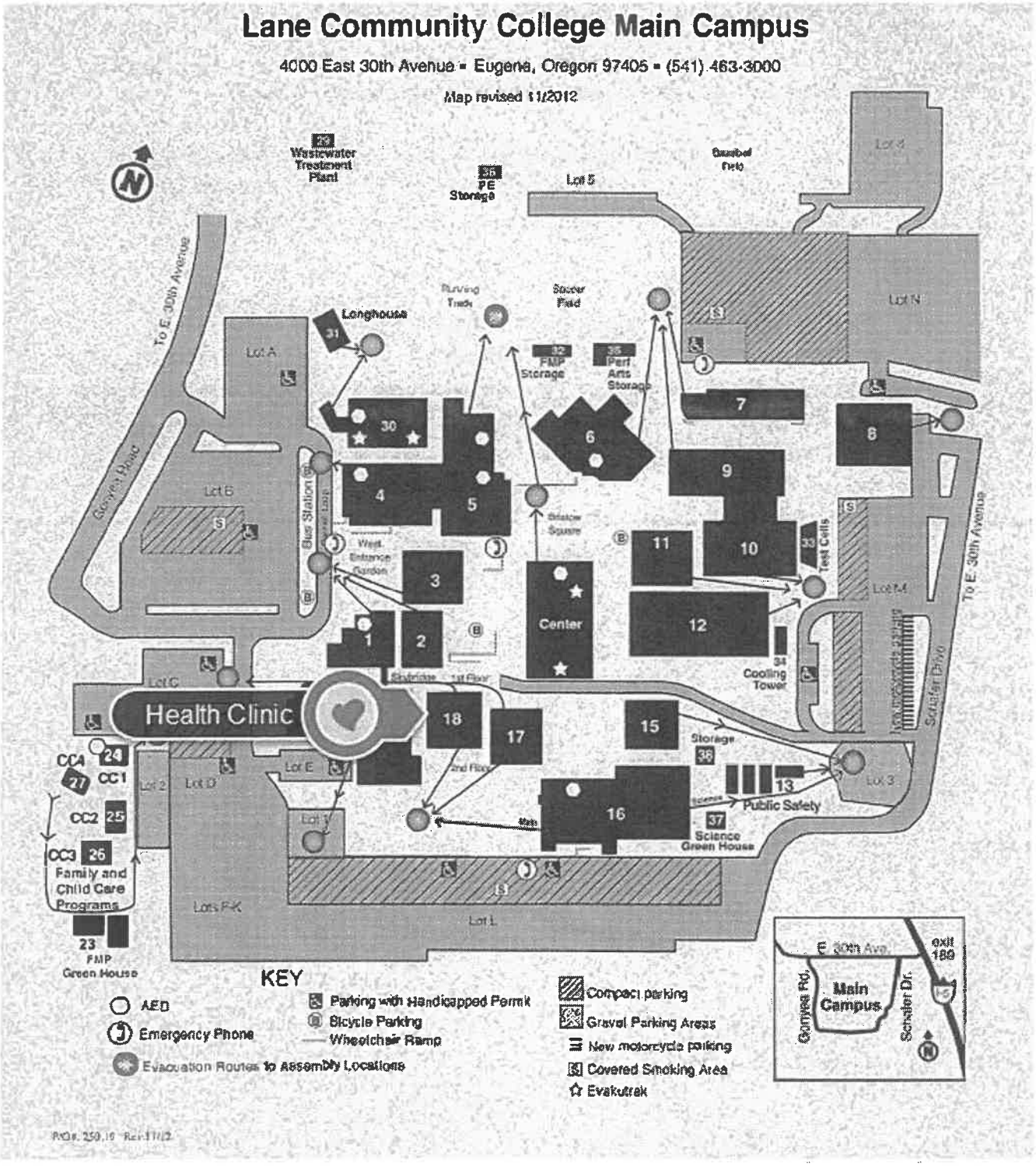
Welcome to the Lane Community College Health Clinic!

Thank you for including Lane Community College Health Clinic as part of your healthcare team. We provide accessible, high-quality medical treatment in a caring and compassionate manner to the students and staff of Lane Community College.

We look forward to working with you to improve your health and meet your healthcare needs. Prior to your first appointment, please complete the attached new patient paperwork. Please bring the completed paperwork to your first appointment, along with a current insurance card and photo ID. On the day of your first appointment, please arrive twenty (20) minutes prior to your scheduled appointment time for check in.

If you have any questions, please contact our office staff at (541) 463-5665.

Thank you,
The Lane Community College Health Clinic Staff


Lane Community College Main Campus
4000 East 30th Avenue • Eugene, Oregon 97405 • (541) 463-3000
Map revised 11/2012
Wastewater Treatment Plant
PE Storage
Lot 5
Baseball Field
Lot 4
Lot N
To E. 30th Avenue
Running Track
Soccer Field
Longhouse
Lot A
FMP Storage
Perf Arts Storage
Garden Road
Lot B
Bus Station
West Entrance Garden
Bristow Square
Test Cells
Lot M
Center
Cooling Tower
Health Clinic
Lot C
Skybridge
Lot E
Lot 2
Lot D
Lot J
Lots F-K
Lot L
Storage
Public Safety
Science Green House
Lot 3
CCA
CC1
CC2
CC3
Family and Child Care Programs
FMP Green House
KEY
AED
Emergency Phone
Evacuation Routes to Assembly Locations
Parking with Handicapped Permit
Bicycle Parking
Wheelchair Ramp
Compact parking
Gravel Parking Areas
New motorcycle parking
Covered Smoking Area
Evakutrak
E 30th Ave
exit 189
Main Campus
Gateway Rd.
Schafer Dr.

Consent / Release Form

Consent for Medical Treatment **Initial** ☐

I understand that by initialing this form, I am consenting to medical and/or surgical treatment including, but not limited to diagnostic tests, lab work, injections, minor operations, removal and disposal of tissues as may be deemed advisable or necessary by the attending health care provider.

Notice of Privacy Practices Acknowledgment **Initial** ☐

I agree that I have received a copy of Lane Community College Health Clinic's (LCCHC) Notice of Privacy Practices.

Release of Information & Records **Initial** ☐

I give LCCHC my consent to use or release my protected health information, and records containing such information, for the following purposes: to carry out my care and treatment; to obtain payment from third parties for health care services and products provided to me; for LCCHC's internal health care operations; and to respond to public health and safety emergencies. My protected health information and associated records may be released to the following class of persons: health care providers treating me and their staff; insurance companies and other third parties obligated to process or pay for health care services and products provided to me; LCCHC employees and other LCCHC authorized individuals present in the Clinic; public health authorities legally authorized to receive information relating to public health and safety concerns; and persons who may be able to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Informed of Ancillary Service Providers and Staff **Initial** ☐

I understand that the LCCHC is part of an educational institution training health care professional staff and that, from time to time, I may have contact with students or other persons who may be observing or facilitating my care under appropriate supervision of clinical staff. Such persons may include, but not be limited to, students of the health profession, administrative or health care professionals, in orientation or training

Assignment of Benefits **Initial** ☐

I understand that this serves as a direct assignment of my medical benefits from Medicare, Medicaid, other government carrier, or any commercial/private insurance carrier, to be paid to LCCHC. If I receive payments directly from my insurance company, I agree to bring them to LCCHC for payment on my account.

Cancellation / No Show Policy **Initial** ☐

I understand that I am expected to provide LCCHC with 24 hours notice if I am unable to attend my scheduled appointment. I understand that if I do not show for my scheduled appointments, I may be prevented from scheduling future appointments and instead be required to be seen on a "walk-in" basis.

Financial Responsibility **Initial** ☐

I understand that I am responsible for any non-covered services or services deemed "not medically necessary" by my insurance company. I understand that if I am unable to pay for services that I have requested, I will have those charges transferred to my L# account with Lane Community College. I further understand that it is the responsibility of my healthcare provider to notify me if a non-covered service is required and to give me the option to decline this service.

My signature below indicates I have read and agree to any section above that is initialed.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____ L: _____

PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

1. You have the right to considerate, respectful care.
2. You have the right to have us explain diseases, treatment, and results in an easy-to-understand way.
3. You have the right to expect that all communications and records about your health care will be treated as confidential, respectful of legal requirements.
4. You have the right to refuse treatment, as permitted by law, and to be informed of the medical consequences of that action.
5. You have the right to voice any concern or complaints that arise, without fear, regarding your health care with your provider or a staff member.
6. You have the right to receive nondiscriminatory care regardless of race, creed, color, religion, gender, gender orientation, national origin, disability, or age.
7. You have the right to involve yourself or your family in any aspect of your care.

Patient Responsibilities

1. Give your provider, clinic staff, and fellow patients respect and consideration. This includes no shouting, threats, cursing, or violence of any kind.
2. Provide complete, accurate, honest information about your health so that the staff can give you the best health care possible.
3. Keep your scheduled appointments or reschedule those appointments in advance.
4. Follow through with your care plan, including follow-up appointments, labs, and completing medications. Be sure you leave every visit with a clear understanding of expectations, treatment goals and future plans.
5. Let us know if you are unable to take your medicine or follow through with your care plan.
6. Discuss your concerns with the provider or a staff member should problems arise.
7. Treat the staff and clients / patients in the Clinic without discrimination regardless of race, creed, color, religion, gender, gender orientation, national origin or age.
8. Be active in your health care decisions. This includes involving your family and/or other trusted adults in any aspect of care that you feel would benefit your care.
9. Understand that your lifestyle choices effect your personal health.
10. Give us feedback so we can improve our services.

To request this information in an alternate
format please contact the Center for
Accessible Resources at 541.463.5150
or accessibleresources@lanecc.edu

Lane Community College

Lane Community College Health Clinic

PATIENT INFORMATION

L#: _____ Appointment Date: _____

Name: _____

Date of birth: _____ State or Country of Birth: _____

Natal Gender (the physical gender you were born with): _____

Your name, date of birth, and natal gender are used to determine your healthcare needs and to bill your insurance. If the information provided does not match your photo id and/or your insurance card, we may not be able to bill your insurance for your visit.

Local Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Contact Phone: ( ) - _____

Can we leave a message on this phone regarding your healthcare? ☐ Yes ☐ No

Email Address: _____

Primary Care Provider (PCP): _____

Mother's Maiden Name & First Name: _____

Patient's Maiden Name or Other Names: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

The following information is optional but allows us to provide more respectful care to our patients.

Preferred First Name or Nickname: _____

Gender Identification: _____ Preferred Pronoun: _____

Insurance _____

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Medical History Form *(Please complete entire form before your visit)*

Today's Date: _____

Patient Name (Please Print): _____ Date of Birth: _____

Occupation: _____ Previous Occupations: _____

Date of Last Examination: _____ Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Domestic Partner ☐Widowed

Personal History: (Update Annually)

ALLERGIES TO MEDICATIONS:

1. _____
2. _____
3. _____
4. _____

MEDICATIONS: List all, including over-the-counter

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

HOSPITALIZATIONS & SURGERIES:	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Immunization History:

Pneumonia Vaccine: ☐Yes ☐No Date: _____

Routine Childhood Immunizations: ☐Yes ☐No

Gardasil Vaccine: ☐Yes ☐No Date: _____

TDaP Vaccine: ☐Yes ☐No Date: _____

Flu Vaccine: ☐Yes ☐No Date: _____

Personal and Family History:

If applicable, please note **WHO** has had problem: M=Mother, F=Father S=Sister, B=Brother, MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM=Paternal Grandmother PGF=Paternal Grandfather A=Aunt, U=Uncle, C=Children

	SELF	WHO	AGE
If deceased, age at death:	☐		
Alcoholism:	☐		
Asthma:	☐		
Cancer or Tumor:	☐		
Clotting/Bleeding Problems:	☐		
Diabetes:	☐		
Epilepsy:	☐		
Heart Problems:	☐		
Hepatitis/Liver Disease:	☐		
High Blood Pressure:	☐		
High Cholesterol:	☐		
Kidney Disease:	☐		
Mental Illness/Depression:	☐		
Stroke:	☐		
Thyroid Problems:	☐		

Other: _____

Please list any problems you are having at this time:

1. _____
2. _____
3. _____
4. _____

Do you have a Living Will/Advanced Directive?

_____ Yes _____ No

If not, would you like to discuss this with your doctor?

_____ Yes _____ No

Routine Checkup - No Problems _____

Personal Habits: *(Update Annually)*

- Exercise (type and how often): _____
- Work: _____ Hours/Day _____ Indoors or Outdoors
- Do you enjoy your work? ☐Yes ☐No
- Participate in Sports/Hobbies? ☐Yes ☐No
- Caffeine (coffee/soda)? ☐Yes ☐No # cups/day _____
- Number of hours of sleep per night: _____
- Do you have any safety issues at home? ☐Yes ☐No
- Alcoholic beverages? ☐Yes ☐No
  If yes, what type and how many drinks daily? _____
- Have you ever been treated for alcoholism? ☐Yes ☐No
- Have you ever been treated for drug abuse? ☐Yes ☐No
- Have you ever used "recreational" drugs? ☐Yes ☐No
  If yes, what type, how often and last date? _____
- Tobacco: Cigarettes ☐Yes ☐No _____# packs/day
  _____Cigars _____Pipe _____Chewing Tobacco _____Snuff
  _____e-Cigarettes
- If you have smoked in the past, when did you quit? _____

FOR MEN ONLY:

Last Colonoscopy: Date _____ Where: _____

FOR WOMEN ONLY:

Hysterectomy

What was the date of your last menstrual period?_____
When was your last pap test?_____
Number of pregnancies_____
Number of live births _____
Date of Colonoscopy Date_____ Where_____
Last Mammogram Date_____ Where _____
Birth Control Method?_____
Have you ever had an abortion?_____

Note: This confidential record of your medical history will not be released without your written permission.

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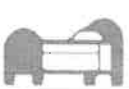
My Medication Log – Keep it Handy

- List all prescriptions, over-the-counter drugs, vitamins and herbs.
- Bring this to every doctor's appointment and if you go to the emergency room or hospital.

Date: _____

Name and Dose of Your Medicine	This Medicine is for my_____	How Much and How Often?				Reminder: When do I take it?
		Morning 	Noon 	Evening 	Bedtime 	
Example: Simvastatin 40 mg	Example: High cholesterol	Example: 1 pill				Example: After I brush my teeth

If you have any problems with your medicine – do not wait. Talk to your health care provider right away.

Patient Name: _____ Name of Primary Care Provider: _____ Primary Care Provider Phone Number: _____