9155 SW Barnes Road, Suite 840
Portland, OR 97225

WELCOME TO SUNSET PEDIATRICS

We appreciate the opportunity to provide your family with pediatric health care. Our policies are outlined here to help familiarize you with our practice. Please be comfortable asking, if you have any questions regarding any of the policies.

OFFICE HOURS - Monday through Thursday from 8:00am to 6:30pm, Friday from 8:00am to 5:00pm, and Saturday from 8:30am to noon.

AFTER HOURS EMERGENCY CARE - Dr. DeVoe, Dr. Ericksen, Dr. Madore, and Dr. Wu are available to our patients by phone 24 hours a day, seven days a week. Should you have an urgent question after hours, please call our office and speak with our answering service. They will contact the Sunset pediatrician or pediatric advice nurse on call. If you believe your child may be in an emergency situation, please call
9-1-1.

APPOINTMENTS - We prefer to see all patients on an appointment basis and request that you call in advance to reserve a time for your child. We cannot guarantee that your child can be seen on a walk-in basis, so please call us if your child is acutely ill so we may make arrangements to see him or her at the first possible time. Sunset strongly enforces our 15 Minute Rule. If you arrive late by 15 minutes or more for a Well Child appointment, you will be asked to reschedule your appointment. If you cannot keep an appointment, please call our office as soon as possible so that the reserved time may be made available for another child. On rare occasions, your doctor may be called out of the office on an emergency. If that happens at a time when you are scheduled for an appointment, you will be notified as soon as the emergency occurs. We appreciate your understanding that medical emergencies are unpredictable.

INSURANCE, COVERED BENEFITS AND BILLING – Sunset Pediatrics accepts most major insurance plans. Please contact your insurance carrier to make sure we are in-network with your specific plan. It may be helpful for you to review your benefits to learn what your plan covers and what is excluded. Although we are familiar with many plans, it is your responsibility to know if your insurance will cover your child's visit. Sunset bills all major insurance plans for our patients. Patients are responsible for payment of their accounts regardless of insurance. If your insurance plan requires an office visit co-payment, it is required at the time of the visit. Sunset utilizes credit card on file for our billing practices and we require a valid credit, debit or HSA/FSA card be kept on file with the practice.

TELEPHONE CALLS – Sunset has dedicated nurses to answer patient phone calls throughout the day. Parents are welcome to call to get answers to routine questions and concerns and to help determine a child's need to come in for an appointment. We do our best to respond to all phone calls as soon as possible and before the end of the day. Non-urgent phone calls are typically returned within 24 – 72 hours.

PATIENT PORTAL – When you arrive for your child's first visit at Sunset Pediatrics, you will be encouraged to sign up for the Patient Portal. We highly recommend signing up for the Portal as this will give you remote access to many aspects of your child's medical record.

Please ask us anytime you have a question. We also welcome any suggestions that may help us improve our service to you.

Oregon Immunization ALERT
New Enrollee Form

↓ Clinic or Attending Provider Stamp ↓	*Provider's office staff:* Place *enrollee* barcode label here:

Please print the following patient information:

Date of birth: ____/____/_____ ☐ Male ☐ Female OR - _____-_____-_____
MM DD YYYY Previous barcode number (if known)

Patient's name:_____
First Middle Last

Parent/guardian name (if minor): _____
First Last

_____ _____
Patient's last name at birth Mother's maiden name
(last name before she was married)

_____ _____
State of birth Primary language
(Country if not USA)

Home address:_____
Street Apt # City State Zip County

Mailing address:_____
(if different) Street Apt # City State Zip County

(_____) _____-_____ (_____) _____-_____
Primary phone number Alternate phone (if any)

_____-_____-_____ _____
Social Security number (optional) Medicaid ID/Insurance number (if applicable)

Comments:	To contact ALERT: Phone: 1-800-980-9431 971-673-0275 Fax: 971-673-0276 Email: OHD.ALERT@state.or.us

If this patient has record of prior immunizations, you may photocopy the record, attach the HISTORY barcode, and submit it with this form. ALERT will enter the information provided.

PEDIATRIC HEALTH HISTORY QUESTIONNAIRE

Date Completed _____

Patient Name_____ ☐ Male ☐ Female

Date of Birth_____ Parent or Guardian Name_____

ALLERGIES (MEDICATIONS, FOODS OR OTHER) _____

_____

HOSPITALIZATIONS, SURGERIES, INJURIES (ORTHOPEDIC, LACERATIONS, ETC.)

_____

_____

_____

REASON FOR VISIT

Well Child Check/Sports Physical ☐ Yes ☐ No

Medical Concern(s) - Please List:

_____

_____

_____

If patient has been treated for any other significant illnesses/medical problems by other providers, please describe the problems and list the physician or medical facility treating him/her.

ILLNESS OR MEDICAL PROBLEM PHYSICIAN/MEDICAL FACILITY

_____

_____

_____

HEALTH HISTORY

Please ✓ the appropriate answer unless otherwise specified. If in doubt about the question, please circle it. Your doctor or nurse will review your answers with you.

___ Parent Completing: Does your child have, or has your child ever had, any of the following?

___ Patient Completing: Do you have, or have you ever had, any of the following?

NEWBORN

☐ Premature ☐ Jaundice requiring treatment ☐ Significant Problems in 1st month

EYES

Vision changes past year?	☐ No ☐ Yes
Wear glasses or contacts lenses?	☐ No ☐ Yes
Eye muscle surgery?	☐ No ☐ Yes

EARS

Repeated infections?	☐ No ☐ Yes
Ear tubes?	☐ No ☐ Yes
Speech problems or delay?	☐ No ☐ Yes
Deafness or decreased hearing?	☐ No ☐ Yes

NOSE AND THROAT

Nose or throat problems?	☐ No ☐ Yes

DIGESTIVE TRACT

Diarrhea?	☐ No ☐ Yes
Constipation?	☐ No ☐ Yes
Recurrent vomiting?	☐ No ☐ Yes
Recurrent abdominal pain?	☐ No ☐ Yes
Bloody bowel movements?	☐ No ☐ Yes

CHEST

Wheezing with exercise?	☐ No ☐ Yes
Asthma/hay fever?	☐ No ☐ Yes
Pneumonia?	☐ No ☐ Yes
Tuberculosis skin test change?	☐ No ☐ Yes

SKIN

Birthmarks or moles?	☐ No ☐ Yes

HEART

Heart murmur?	☐ No ☐ Yes
Chest pain?	☐ No ☐ Yes
High blood pressure?	☐ No ☐ Yes
Congenital heart problem?	☐ No ☐ Yes

BLOOD

Anemia? (Low Iron?)	☐ No ☐ Yes
Bleeding or easy bruising?	☐ No ☐ Yes

URINARY TRACT

Congenital Kidney Disorder/Prob?	☐ No ☐ Yes
Bed wetting problems?	☐ No ☐ Yes
Infection one or more times?	☐ No ☐ Yes

MUSCULO-SKELETAL

Arthritis?	☐ No ☐ Yes
Painful or swollen joints?	☐ No ☐ Yes
Scoliosis/abnormal curve of back?	☐ No ☐ Yes

NEUROLOGICAL

Headaches?	☐ No ☐ Yes
Convulsion, seizure, or fit?	☐ No ☐ Yes

GENERAL

Development or milestone delay?	☐ No ☐ Yes

IS PATIENT PHYSICALLY HANDICAPPED OR LIMITED IN ANY WAY?

☐ No ☐ Yes

If yes, please name or describe:_____

_____

_____

DO YOU HAVE ANY QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR DOCTOR?

☐ No ☐ Yes

Please list:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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PATIENT INFORMATION

TODAY'S DATE: _____ /_____/_____

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ /_____/_____ Sex: ❑M ❑F Preferred Name: _____ Language: _____

Preferred Pronouns: (Please list) _____ Preferred Gender Identity: (Please list) _____

Race: ❑ White ❑ Black/African American ❑ Asian ❑ American Indian/Alaskan Native ❑ Prefer Not to Answer

Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic or Latino ❑ Prefer Not to Answer SSN: _____ - _____ - _____

Address: _____ Apt# _____

City: _____ State _____ Zip _____

Patient's Primary Care Physician: _____ How were you referred to Sunset Pediatrics? _____

SIBLINGS

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____ /____/____ Sex: ❑M ❑F

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____ /____/____ Sex: ❑M ❑F

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____ /____/____ Sex: ❑M ❑F

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____ /____/____ Sex: ❑M ❑F

PRIMARY GUARDIAN INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ /_____/_____ Sex: ❑M ❑F Relationship to Patient: _____ SSN: _____ - _____ - _____

Driver's License Number: _____ Address: Same as Patient ❑ Yes ❑ No (if no, please enter below)

Address: _____ Apt# _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Email Address:

_____

Preferred method of appointment confirmation: ❑ Phone call (❑Home ❑Cell) ❑ Text Message (Number: (_____) _____-_____

Employer: _____Work Phone: (_____) _____-_____

SECONDARY GUARDIAN INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Birth Date: _____ /_____/_____ Sex: ❑M ❑F Relationship to Patient: _____ SSN: _____ - _____ - _____

Driver's License Number: _____ Address: Same as Patient ❑ Yes ❑ No (if no, please enter below)

Address: _____ Apt# _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Email Address: _____

Preferred method of appointment confirmation: ❑ Phone call (❑Home ❑Cell) ❑ Text Message (Number: (_____) _____-_____

Employer: _____Work Phone: (_____) _____-_____

sunset pediatrics

Patient Name: _____ Birth Date: _____ /_____/_____

EMERGENCY CONTACTS

(**Other than primary and secondary guardian(s))

Emergency Contact #1

❑ Decline to Add

Last Name: _____ First Name: _____ Middle Name: _____

Sex: ❑M ❑F Relationship to Patient: _____ ***To authorize consent for treatment, please see attached consent form***

Address: _____ Apt# _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Emergency Contact #2

❑ Decline to Add

Last Name: _____ First Name: _____ Middle Name: _____

Sex: ❑M ❑F Relationship to Patient: _____ ***To authorize consent for treatment, please see attached consent form***

Address: _____ Apt# _____

City: _____ State _____ Zip _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Company Name: _____ Effective Date: _____ /_____/_____

ID Number: _____ Group Number: _____

Address: _____ City: _____

State _____ Zip _____ Phone: (_____) _____-_____

Subscriber Name: _____ Birth Date: ____ /____/____ Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Company Name: _____ Effective Date: _____ /_____/_____

ID Number: _____ Group Number: _____

Address: _____ City: _____

State _____ Zip _____ Phone: (_____) _____-_____

Subscriber Name: _____ Birth Date: ____ /____/____ Relationship to Patient: _____

_____ Date: ____ /____/____

Signature Print Name and Relationship to Patient

Patient Name: _____ Birth Date: _____ /_____/_____

Pharmacy Authorization

Sunset Pediatrics sends the majority of prescriptions electronically, and by signing this consent form you are agreeing that Sunset Pediatrics can request and use your prescription medication history from other healthcare providers and/or third-party benefit payers for treatment and payment purposes.

Pharmacy Name: _____ Phone: (_____) _____-_____

Address: _____ City: _____ State _____ Zip _____

_____ Date: _____ /_____/_____

Signature Print Name and Relationship to Patient

AUTHORIZATION AND CONSENT FOR TREATMENT AND ASSIGNMNET OF BENEFITS

I hereby authorize Sunset Pediatrics to provide medical services to the above-named patient and use and release medical information required for treatment, payment, and health operations.

_____ Date: _____ /_____/_____

Signature Print Name and Relationship to Patient

FINANCIAL RESPONSIBILITY

I also assign Sunset Pediatrics all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I also understand that failure to make insurance co-payments at the time of the visit will result in additional charges. I have received a copy of the current Notice of Privacy Practices.

_____ Date: _____ /_____/_____

Signature Print Name and Relationship to Patient

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AUTHORIZATION AND CONSENT FOR TREATMENT OF A MINOR CHILD

(**Other than primary and/or secondary guardian(s) – One form per child, please)

I, the undersigned parent, or legal guardian of ____________________________________Patient's Birth Date: _____ /_____/_____ authorize the following individual(s) to accompany my child, make decisions for treatment by a physician, and sign any necessary waivers at Sunset Pediatrics in my absence.

Last Name: ____________________________________ First Name: _____________________________ Middle Name: ____________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

Last Name: ____________________________________ First Name: _____________________________ Middle Name: ____________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

Last Name: ____________________________________ First Name: _____________________________ Middle Name: ____________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

Last Name: ____________________________________ First Name: _____________________________ Middle Name: ____________________

Address: ____ Apt# __________ City: ________________ State ______ Zip ______________

Sex: ❑M ❑F Relationship to Patient: _____________________ Home Phone: (_____) ______-_______ Cell Phone: (_____) _______-_______

I understand that this consent authorization is given in advance of any specific diagnosis, treatment, or hospital care being required in order to provide authority for a licensed physician to render any and all diagnosis, treatment, or hospital care deemed advisable by the physician attending the child. I understand that I am responsible for setting any cost arising from this care provided in my absence.

This consent will remain in effect until the child is 18 years of age unless noted here: ______/______/______. (Date to end consent)

❑ I decline this consent to treat for my child for any person(s) other than the primary and/or secondary guardian(s).

(Please sign even if declining authorization)

____ Date: _____ /_____/_____

Signature Print Name and Relationship to Patient

FINANCIAL POLICY

Sunset Pediatrics is committed to providing your child with the best possible medical care, and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. We participate with most insurance plans. All insurance plans have specific rules and regulations regarding the use of certain labs and treatment centers, as well as referrals to specialists. We ask that you be aware of your plans directives and inform the doctors of them so that they can try as much as possible to keep within the scope of your plan. It is important for you to contact your insurance company if you have any questions regarding your benefits, and for you to know what your payment obligations will be at the time of service.

Please note, Sunset is an independent medical office and you will receive a separate bill for laboratory, anesthesiology, radiology and hospital services.

IDENTIFICATION

Please provide a valid driver's license or state ID card, insurance cards and any necessary forms for all appointments so your insurance can be billed in a timely and accurate manner. Your insurance card contains valuable information regarding coverage and benefits. Please notify our office immediately when you change medical insurance, home address or telephone numbers.

COPAYMENTS AND DEDUCTIBLES

Depending on your insurance policy, a copayment/deductible may be required at the time of service. These payments are expected to be made at the time of your appointment. We accept payment via cash, check, Visa, MasterCard, Discover or American Express. We also accept Health Savings Account (HSA) cards for payment. If you fail to make a copay at the time of service, a $15 billing fee will be added to your account.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan and have not yet paid your deductible in full, it is likely that any non-preventative services will require payment once your insurance policy has processed the claim. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself whoever brings the child in is prepared to make all payments.

CREDIT CARD ON FILE

Since 2019 Sunset Pediatrics requires all patients to keep a card on file in order to be considered active patients. When you come in for your child's visit, we will ask you to provide a credit, debit card, HSA or HRA to keep on file for your child's account. To insure the highest level of data protection, your card information is not stored at Sunset and is housed securely off-site with our PCI and HIPAA compliant card processing company. After your child's appointment, Sunset will courtesy bill any insurance plans we are contracted with and once they have processed your claim

they will send you an Explanation of Benefits (EOB) notifying you of your share of the financial responsibility. After your insurance has processed and Sunset has been notified of your remaining responsibility you will receive a statement from Sunset, along with a notification of when the remaining balance owed by you will be charged to your credit/debit card on file. After your card is charged and you will be emailed a receipt. The maximum amount your card will ever be charged at one time is $250. If your balance is larger than that, a member of our billing staff will contact you to arrange payment. If you wish to be on a payment plan, you must contact our office as soon as you receive your EOB and/or statement and we will be happy to set that up.

NON-SUFFICIENT FUNDS

When checks are returned to Sunset Pediatrics for non-sufficient funds, a $35 charge will be added to your account, and we will no longer be able to accept checks as forms of payment for outstanding balances.

NO PROOF OF INSURANCE

If you do not provide proof of valid insurance coverage or Sunset is unable to verify eligibility at any appointment, you will be required to sign a financial responsibility waiver at the time of service. This waiver states you will be responsible for full payment of any services performed at that visit at the time of service.

PATIENTS WITHOUT INSURANCE COVERAGE

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount of 20% will be applied to the bill if paid at the time of service. New patients must pay total amount for services at the time of their appointment. For established patients, a $100 deposit may be made, and any remaining balance can be set up on a payment plan.

GOOD FAITH ESTIMATES

Patients who don't have insurance or who are not using insurance have the right to receive a "Good Faith Estimate" of how much their medical care will cost.

Your Rights Under the No Surprises Act

- You have the right to receive a Good Faith Estimate for the total expected cost of your visit. This includes any known related costs, such as routine immunizations, screenings, and labs. Estimates do not include unknown or unexpected costs. Charges for unforeseen services, such as labs, tests, x-rays, or same-day procedures will be added to your final bill.
- Healthcare providers are required to provide a Good Faith Estimate in writing at least one (1) business day before your scheduled appointment. You can also ask us or any healthcare provider for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy of your Good Faith Estimate.

COLLECTIONS

Any amount indicated as patient responsibility by your insurance company is due upon receipt of that determination. Accounts with balances exceeding 60 days will incur a late fee of $50. Accounts with balances exceeding 90 days will be released to a collection agency. In the unfortunate event that we need to assign an account to a collection agency, an additional fee of $150 will be added to the delinquent balance on the account. Families with any account sent to collections will automatically be dismissed from the practice.

PATIENTS 18 YEARS AND ABOVE

You will be responsible for charges accrued by children who have turned 18 until you notify Sunset Pediatrics in writing, prior to services being provided, that you no longer accept financial responsibility. State laws prohibit us from discussing medical information with the parent, even if they carry insurance on the patient, unless the patient gives permission and completes a release of information form.

CANCELLATION/NO SHOW FEE

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to see the doctor. We require 24 hours' notice to reschedule or cancel any appointment. Failure to notify the clinic at least 24 hours prior to the appointment will result in a no-show fee of $75. Three or more no show appointments within a family (among all siblings) may result in dismissal from the practice. New patients that do not provide notice and miss their first appointment will be advised to seek care at another pediatric clinic.

PATIENT PRIVACY PRACTICES

We are committed to ensuring your child's Protected Health Information (PHI) remains confidential. Your child's paper and electronic medical records are safeguarded and released only with your consent, or to your insurance carrier, other medical professionals directly involved with your child's care, or as required by law. Our Notice of Privacy Practices policy, which explains how your child's medical information may be used and disclosed, is available for your review or you are welcome to have a copy. If you would like to release your child's PHI to another doctor or facility, you will be required to fill out a separate form to request records.

MISSED APPOINTMENT POLICY/OUTSIDE SERVICE FEES:

We must be notified at least 24 hours in advance of an appointment cancellation/need to reschedule. A $75 fee may be charged for a no show or late cancellation of appointments. Payment of this fee is the responsibility of the patient and is not covered by insurance. You may incur additional charges from providers outside your network for procedures done outside of our clinic that may not be a part of your exam. This can include laboratory, anesthesiology, radiology and/or hospital service fees.

FAQS

What is a deductible and how does it affect me?

An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

How will I know when my deductible has been met?

You can call your insurance at any time to check on how much of your deductible has been met. Some insurances have this information available online. You should receive notification from your insurance company with how much they paid or did not pay when they send you an Explanation of Benefits (EOB).

What if I don't know what my insurance benefits are?

Your insurance plan is a contract between you and your insurance company, even if your employer provides it. We provide medical services and submit the claim on your behalf if it is an insurance plan we contract with. We do our best to verify your benefits prior to the appointment (sick or well) to make sure we collect the appropriate amount owed or to make sure your visit will be covered by your plan; however, it remains the policy holder's responsibility to know their insurance policies.

But wait, I'm nervous about leaving you my credit card information.

We do not store your sensitive credit card information in our office. Once the card is swiped, only the last four digits of your account number is visible to our staff. Your account information is stored on with a secure, PCI and HIPAA compliant card processing company and is only accessed to process your payment and email you a receipt once the payment is processed. Your credit card on file is considered protected health information under HIPAA, and therefore far more secure than most retail establishments as it relates to identity theft.

I have a Health Savings Account (HSA) or a Flex Spending Account (FSA), can I leave that on file?

Yes, you can keep your HSA, HRA or FSA card on file, however, we may require an additional card to be kept on file should the funds in your account become insufficient.

Isn't this policy the same as "signing a blank check"?

No, Sunset Pediatrics will only charge your card for the amount your insurance company states is your responsibility. All credit card contracts give cardholders the right to challenge any charge against their account.

I have insurance through the State of Oregon Health Plan. Am I required to place a card on file?

You will be required to place a card on file if you request appointments for elective/uncovered services such as wart removals or circumcisions.

DIVORCED OR SEPARATED PARENT/GUARDIAN POLICY

OUR FOCUS IS THE CARE AND WELLBEING OF YOUR CHILD(REN). WE ARE UNABLE TO MEDIATE BETWEEN ANY PERSONAL ISSUES CONCERNING THE CHILD'S PARENTS OR GUARDIANS.

- Please make decisions regarding vaccinating your child(ren), circumcision, reproductive education, etc. prior to visiting our practice.

- Either parent or legal guardian can schedule an appointment for their child, be present for the visit, and/or obtain a copy of the child's medical record. Any restrictions on parental involvement in the child's care must be clearly presented via a court issued document, a copy of which should be sent to Sunset. Unless such a court order exists in the child's record, we cannot limit the other parent's involvement in your child's care.

- Payment (co-pays, deductibles, etc.) is due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. We will collect payment due from the parent who brings the child to the visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

- Both parents/legal guardians can sign a "Consent to Treat" form. This means other persons (like grandparents, nannies, etc.) are authorized to bring your child to our practice and can consent for treatment during that visit. We will not be involved in any disputes regarding named individuals on your child(ren)'s consent to treat form unless otherwise ordered by court documentation.

- Both parents/legal guardians can see who is named on each other's forms; however, we will not comply with requests to eliminate names on the other's form, unless instructed by the Court. Please refer these requests to your attorney.

Additionally, Sunset providers and staff cannot:

- Call the non-attending parent for consent prior to treatment or inform the other parent whenever visits are scheduled.

- Call the non-attending parent after a child's visit to communicate care information.

- Tolerate appointment scheduling/cancelling patterns of behavior between parents.

Please note: should the issues that come between parents become disruptive to our practice or impede the care of children, we reserve the right to discharge your family from further treatment.

FINANCIAL RESPONSIBILITY AGREEMENT

I hereby acknowledge that:

- Sunset Pediatrics will bill all insurance companies that they are contracted with as "network" providers as a courtesy to their patients. I authorize Sunset Pediatrics to release any information requested by the insurance company/companies or respective representatives and act as my agent to secure payment for all services rendered.
- I authorize all insurance payments to be made directly to Sunset Pediatrics.
- As the patient or legal guardian of a minor patient I acknowledge full financial responsibility for services rendered by Sunset Pediatrics to me or my dependents and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, co-pays, deductibles, co-insurance, pre-existing clauses, excluded conditions and/or termination of coverage.
- I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility.
- I acknowledge that I have received access to the "Notice of Privacy Practices" for Sunset Pediatrics. I have read and understand the "Oregon Referral Rights" policy.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.
- I understand that I accept the terms outlined in each of the above stated policies.

_____

Signature Date

_____

Print Name Relationship to Patient

Children's Names

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____/____/____

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____/____/____

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____/____/____

Last Name: _____ First Name: _____ Middle Name: _____ Birth Date: ____/____/____

Patient Portal Policy

WHAT IS A PATIENT PORTAL?

Sunset Pediatrics provides this site for the exclusive use of its established patients. The patient portal is designed to enhance patient - provider communication. The secure web portal is a way to view certain health information for your child and communicate non-urgent information with our staff.

Some of the features offered with this service include:

- Ability to view patient demographic information and send requests to our staff to update this information. If you have access to more than one child's account, you will need to make updates for each patient individually
- Limited health summary information after your visit with one of our pediatricians
- Patient statements and online payments
- Immunization Records
- Messaging with your provider's medical staff for non-urgent questions

HOW DO I SIGN UP FOR THE PORTAL?

Once we have a signed consent form on record, we will send you a secure email to the email address you have provided; follow the login instructions in the email and input your username and temporary password. Once you log in it will ask you to create a new password.

PATIENT PORTAL IS NOT INTENDED FOR THE FOLLOWING:

- Diagnosis or extended treatment; all advice given over the patient portal is for routine inquiries that are non-urgent in nature. Should the medical team need additional information, they will reach out to find a time for a phone follow up. All response via the patient portal is at the discretion of the physician and his or her staff. They reserve the right to require an in-person visit to provide diagnosis/ treatment.
- Emergency communication. Communication on the portal is restricted to non-urgent issues. If your child is experiencing an emergency, please dial 9-1-1 or go to the nearest emergency room. Our system will notify us when we have messages. We will normally respond to all messages within 24-48 hours after receipt.

PROTECTING YOUR CHILD'S PRIVATE HEALTH INFORMATION AND RISKS:

While we work hard to ensure that all communication through the portal is secure, it is imperative that Sunset has your correct email address and that you inform us of any changes to your email. It is your responsibility to make sure your login information is protected from unauthorized persons. If you think someone has learned your password, please promptly change it or call our office. Your email address is confidential and protected information, Sunset will never purposeful share this information with a third party.

ACCESS FOR CHILDREN 14 -17 YEARS OLD:

According to Oregon Law (ORS 109.640), minors 14 years of age or older can give consent to treatment without parent consent, and as such, we need to extend confidentiality to those patients as we would an adult. For this reason, patients 14 and older who wish their parent to have access to the Patient Portal will be asked to sign a release form granting their responsible party access to this information. Without a signed release form, access to the portal account will be disabled for responsible parties when the patient turns 14.

Patient Portal Access Form

Patient Name: _____ Birth Date ____ /____ /____ Sex: ☐ M ☐ F

Parent or Legal Guardian: _____

ACCESS TYPE	WHAT IS REQUIRED
☐ Your minor child (age 13 or younger)	
☐ Your minor child (age 14 to 17)	Page 2 of this form – Authorization to Use and/or Disclose Protected Health Information (signed by patient)
☐ Your adult child (age 18+)	Page 2 of this form – Authorization to Use and/or Disclose Protected Health Information (signed by patient)
Please return Portal Access Forms to the clinic or fax them to 503-291-1584	

RESPONSIBLE PARTY REQUESTING ACCESS

Name: _____ Birth Date ____ /____ /____

Address (if different than patient's): _____

Phone: _____ Email: _____

ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form and the policies regarding the patient portal and those that appear at login. I understand the risks associated with online communications between my provider and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the policies set forth in the log in screen, as well as any other instructions that my provider many impose to communicate with parents via online communications. I understand that the patient portal is an optional service and that Sunset Pediatrics reserves the right to suspend or terminate it at any time and for any reason. I understand and agree with the information that I have been provided.

Responsible Party Signature:_____

Relationship to patient: _____ Date:_____

FOR INTERNAL USE ONLY

☐ Reviewed and verified form. _____ initials
☐ Reviewed and verified Authorization Form for request types 2 and 3. _____ initials
☐ Proxy activated in Aprima _____ initials
Scan forms into Aprima _____ initials

Portal Authorization to Disclose Protected Health Information

The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. Refusal to sign this authorization will not affect my ability to obtain health care services or reimbursement for services unless this authorization is required to bill my insurance company.

I authorize the disclosure of all information maintained in my Portal Account, including the following specific information as it may pertain to me (the following items must be initialed to authorize access to your Portal Account):

_____ HIV – positive test results and HIV diagnosis

_____ Mental health information and/or records

_____ Genetic testing information and/or records

_____ Other sexually transmitted diseases

_____ Drug/alcohol diagnosis, treatment or referral information. Federal regulations require you to describe how much and what kind of information is to be disclosed: _____

Federal and/or state law may restrict re-disclosure of HIV-positive test results and HIV diagnosis, other sexually transmitted disease information, mental health information, genetic information and drug/alcohol diagnosis, treatment or referral information.

The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing my health information to someone else, and this authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless this authorization is necessary to determine if I am eligible to enroll in the health plan.

I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described in this authorization. Unless revoked earlier, this authorization will remain in effect for so long as I maintain a Patient Portal account. However, if I am under the age of 18, this authorization will expire when I turn 18 years old.

_____

Signature of Parent/Legal Guardian/Patient 18+ | Print Name/Relationship to Patient | Date

_____

Signature of Patient (14-17years old) **REQUIRED** | Print Name | Date

Authorization to Use/Disclose Health Information

Sunset Pediatrics, LLC – 9155 SW Barnes Road Suite 840 Portland, Oregon 97225
Phone: (503)296-7800 Fax: (503)291-1584 Email: records@sunsetpediatrics.com

Patient Name: _____ **Date of Birth**: _____/_____/_____ **Phone:** (_____) _____

I authorize Sunset Pediatrics to:

Receive my specific health information from the person(s) listed below:

Clinic/Hospital/Name of Person(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

My health information may be: (check all that apply): ❑ Physically Exchanged ❑ Electronically Exchanged

Indicate the type of information to be released:

❑All healthcare information (if patient is transferring care)

❑Information specific to the following treatment, condition, dates of treatment, or other (please explain):

_____

Reason for Disclosure: ❑Transferring Care ❑Legal ❑Personal Use ❑Insurance ❑ Immunizations Only ❑Other (please explain):

_____

Protected or Sensitive Information

Sunset Pediatrics reserves the right to reject this authorization form if the legal authority of the representative cannot be validated. 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:

****The following types of sensitive information will NOT be release without INITIALS:**

____ HIV/AIDS Information ____ Birth Control/STI Information ____ Genetic Testing Information

____ Mental Health Information (Incl. ADHD/Developmental Disability Information) ____ Drug/Alcohol Diagnosis, Treatment, or Referral Information

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. 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 do not need to sign this authorization. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstances when refusal to sign means you will not receive healthcare services is if the healthcare services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

To revoke this authorization, please send a written statement to 9155 SW Barnes Rd. Suite 840 Portland, OR 97225 Attn: Medical Records Coordinator and state that you are revoking this authorization.

I have read and understand this authorization. Unless revoked, this authorization expires the earlier of 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

X _____ X _____ X ____/____/____

Signature of Parent or Legally Responsible Person (REQUIRED) | Print Name **AND** Relationship | Date Signed

X _____ X _____ X ____/____/____

Signature of Patient if 14+ (REQUIRED) | Print Name | Date Signed

*Rev. 12/2023.