Deschutes Rim Health Clinic
1605 George Jackson Rd
PO Box 219
Maupin, Oregon 97037
Phone: 541-395-2911
Fax: 541-395-2912
Clinic Hours:
Mon – Thurs 9:00am – 5:30 pm
Friday 9:00 am – 1:00 pm

Welcome to Deschutes Rim Health Clinic!

Thank you for choosing Deschutes Rim Health Clinic for your healthcare needs. We are honored to be part of your care journey and look forward to providing you with compassionate, confidential, and patient-centered care.
Below is helpful information to ensure you receive the best care possible.

Please return the enclosed paperwork by dropping it off at the clinic; mailing to PO Box 219, Maupin, OR 97037; or via email to Clinicmanager@deschutesrimhealthclinic.org
Once we receive the paperwork, we will call you to schedule your appointment.

General Clinic Guidelines

Lab Results: If you have labs drawn at your appointment, you'll receive a copy of the results in the mail with the provider's notes, or a phone call if your care plan needs to be changed because of the results. If you have questions, feel free to call and schedule a follow-up.

Referrals and Diagnostic Imaging: When imaging studies or consultations are ordered, you will be contacted directly by the clinic or imaging center to schedule your tests or appointments. If you have not heard about scheduling after 2 weeks, please contact our office to help follow-up on the order.

Prescription Refills: Please request refills through your pharmacy first. If the pharmacy is unable to process it, contact us directly. Allow up to 3 business days for refill requests to be completed.

After-Hours or Emergency Care: If you are experiencing a medical emergency, call 911 or go to the nearest emergency room. For non-urgent issues outside of our office hours, you may call the clinic to leave a message, and we will respond during the next business day.

DESCHUTES RIM
HEALTH CLINIC

Authorization for Release of Health Information

Patient: _____ _____
Last First Middle Date of Birth

I specifically authorize the release of the following records if such records exist:

History & Physical	Medications	Diagnostic Tests
Chart Notes	Diagnoses	Operative Reports
Labs	Mammogram	Radiology
Immunizations	Pap Smear	Consultation Reports
Food/Drug Allergies	Colonoscopy	Pathology Reports
Dental Treatment Plans	Dental X-Rays	

From: _____
Name of Medical Office or Provider

_____
City State Zip Code Telephone Fax

To: Deschutes Rim Health Clinic, PO Box 219, Maupin, OR 97037
Fax: 541-395-2912 Email: Clinicmanager@deschutesrimhealthclinic.org

For the purpose of: Continuation of Care For the Date(s): Past 10 years

If the records contain any information of the type listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I **initial** in the space next to the information:

HIV/AIDS: _____ Mental Health: _____ Genetic Testing: _____

Alcohol/drug diagnoses, treatment, referral: _____

I have reviewed and understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected under federal law. Unless revoked earlier, this authorization shall remain in effect for 1 year after signing this authorization. I understand I can revoke this authorization at any time by sending a letter to Deschutes Rim Health Clinic. The cancellation will not affect any information that was already disclosed. Deschutes Rim Health Clinic cannot condition treatment or eligibility of benefits on whether the authorization is signed.

_____ _____
Patient's Signature Date

_____ _____
Other Authorized Person (print name) Relationship to Patient

_____ _____
Authorized Person Signature Date

Revised 06/2025

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DESCHUTES RIM
HEALTH CLINIC

Patient Registration

Current Patient Information **Date: _____**

Full Name:	Preferred Name:
Physical Address:	City-Zip Code:
Mailing Address:	Marital Status:
Home Phone:	Mobile Phone:
Email:	Social Security #:
Date of Birth	Gender:

Guarantor Information, If not Self

Full Name:	Relationship:
Mailing Address:	
Home Phone:	Cell Phone:
Date of Birth:	

Emergency Contact

Full Name:	Relationship:
Home Phone:	Cell Phone:

Primary Insurance Information **Secondary Insurance Information**

Insurance Plan Name:	
Insured Name:	
Subscriber Number:	
Group Number:	

Pharmacy

Name:
City, State:
Phone Number:

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HEALTH CLINIC

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ADULT MEDICAL HISTORY FORM

Patient Name _____ Date of Birth _____ Today's Date _____

Medical Conditions: Please list all past and current health problems you have experienced. If you no longer have the condition, mark **P** for Past. If you still deal with the condition, take medication for it, or see a specialist regularly to monitor it, mark **C** for Current.

PROBLEM	YEAR STARTED	PAST (**P**) OR CURRENT (**C**)?

Allergies: Please list any allergies to medications, iodine, shellfish, tape, or latex.

☐ NO KNOWN ALLERGIES

ALLERGY	TYPE OF REACTION

Medications: Please list all prescription and over-the-counter medications you use, including eye drops, inhalers, vitamins and herbal supplements. Write down dose and how you take it as well (once a day, twice a day, etc.)

Surgical History: Please list any major surgeries you have had, and the approximate year that you had the procedure.

PROCEDURE	YEAR

Family History: Please list any serious health problems that your biologic relatives have experienced, such as cancer, diabetes, depression, etc. Please indicate which of your relatives have the condition and how old they were at the time of diagnosis, if you know.

CONDITION	FAMILY MEMBER	AGE

Preventative Health History:

Screening Tests:

TEST	YEAR DONE
Colon Cancer Screening: Please circle any of the tests you have had for this screening Colonoscopy Cologuard stool DNA FIT stool blood cfDNA Blood Test (such as ColonSentry)	
Breast Cancer Screening: Mammogram	
Cervical Cancer Screening: Pap Smear	
Osteoporosis Screening: Bone density (DEXA) scan	
Cholesterol blood test	
Hepatitis C virus (HCV) Infection	
Human Immunodeficiency Virus (HIV) Infection	

Immunizations:

VACCINE	YEAR(S) DONE
Pneumonia (Prevnar 13, Prevnar 20, Pneumococcal 23)	
Tetanus-Pertussis (Adacel, Boostrix)	
Shingles (Shingrix, Zostavax)	
RSV (Arexvy, Abrysvo)	
COVID-19	
Hepatitis B virus	
Human papilloma virus	

Health Risk Questions:

In the past 2 weeks, have you felt down, depressed or hopeless?	☐ No	☐ Yes
In the past 2 weeks, have you lost interest in activities?	☐ No	☐ Yes
How many times in the last year have you taken >4 alcoholic drinks in 1 day if you are a woman, or >5 drinks in 1 day if you are a man?	☐ Never	☐ At least once
In the past year have you used a recreational drug, or a prescription drug for non-medical reasons?	☐ No	☐ At least once
Do you use tobacco?	☐ No	☐ Yes
Have you used tobacco in the past?	☐ No	☐ Yes
If yes, when did you quit?		

Advance Directives:
Do you have an Advanced Directive?

☐ Yes Please Specify: ☐ Living Will ☐ Durable Power of Attorney for Health ☐ Other:_____

☐ No If no, would you like information about Advanced Directives today? ☐ No ☐ Yes

Additional Health History:

Please use this area for extra space, or for additional information not listed elsewhere on this form that you would like your health care team to know about you.

Financial Policy

Patient: _____

Below is an outline of the Deschutes Rim Health Clinic's financial policies to promote compliance, patient satisfaction, and efficiency.

- We are participating providers for most insurances.
- Patients are responsible for knowing their benefits, restrictions, limitations, and obtaining any necessary referrals or authorizations.
- We bill insurance companies as a courtesy. We make every effort to help patients collect from an insurance claim; the patient is responsible for their portion of the bill.
- All copays are due at the time of service. All coinsurance, deductibles, and non-covered charges are due as soon as they are known. Payments can be made by cash, check, or credit/debit card.
- A valid insurance card and ID are requested at each visit.
- We work with our patients regarding setting up payment terms if unable to pay the full amount.
- You may qualify for the Sliding Fee Discount Program. The Sliding Fee Discount Program is based on your household size and income. Please ask us for the Sliding Fee Discount Program application. You can also review it on our website at www.deschutesrimhealthclinic.org
- If there is an outstanding balance 120 days after the date of the first statement and there has been no attempt or an inconsistent attempt to pay the amount due, we may turn your account over to a collections agency. If your account does go to an outside agency, you agree to pay any court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balances.
- Patients will be expected to pay a $25 returned check fee for any checks that are returned.
- A pay in full discount of 10% is available on all charges (except copays and already discounted services) if paid within 30 days of the first patient statement.
- You may request a full copy of the Billing & Collection Policy

When you make payments for services provided, you enable us to keep our doors open. You are investing in your future and ours. We understand sometimes circumstances do not enable prompt payment, thus your communication is key to a healthy financial partnership.

_____ _____

Patient or Patient Representative Signature Date

_____

Relationship to Patient (if not patient)

DESCHUTES RIM
HEALTH CLINIC

No Show, Late Cancellation, or Cancelled Appointment Policy

Patient: _____

Deschutes Rim Health Clinic wants to thank you for choosing the clinic for your healthcare needs. To accommodate all patients, reduce scheduling disruptions, and offer optimal care, we are implementing the following policy for no-show, late cancellation and cancelled appointments.

No-show and late cancellations cost the clinic money and take time away from patients who could have taken your appointment.

Policy

- Please arrive at least 10 minutes early for your appointment
- You must provide at least 24 hours' notice to cancel or reschedule an appointment
- If you arrive 10+ minutes late for the appointment, it may be considered a no-show and may need to be rescheduled

After the first and second no-show/late cancellations, you will be charged $25 and receive a letter reminding you of this policy.

After the third no-show/late cancellation, you will be charged $50 and must sign a letter of understanding in order to continue medical care and adhere to specific appointment scheduling requirements.

After the fourth no-show/late cancellation, you will be charged $50 and must sign an agreement which indicates your appointments will no longer be made more than 24 hours in advance. You will be responsible for calling the clinic the day before or day of for a requested appointment

Cancelled appointments: If you continuously cancel appointments, even with 24+ hours' notice, that cause scheduling and financial disruptions, you may be asked to sign a letter of understanding in order to continue medical care and adhere to specific appointment scheduling requirements.

By signing below, I understand and will adhere to the above policy.

_____ _____

Patient/Guarantor Signature Date

DESCHUTES RIM
HEALTH CLINIC

Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, dental, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent continues in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily consent for the provider (Medical Doctor, Dentist, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and/or any other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to their contents.

_____ _____ _____

Signature of Patient or Representative | Patient Date of Birth | Date

_____ _____

Printed Name of Patient or Representative | Relationship to Patient

Revised 06/2025

DESCHUTES RIM
HEALTH CLINIC

HIPAA Acknowledgement and Consent

_____ _____

Patient Name Date of Birth

I understand that my health information may include information both created and received by Deschutes Rim Health Clinic (DRHC), that it may be in the form of written or electronic records or spoken words, and may include information about my health and mental health history, health status, symptoms, examination, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that DRHC may use and disclose my health information for:

- Making decisions about and planning for my care and treatment (including activities performed by a physician, nurse practitioner, or other healthcare provider directly delivering care at DRHC).
- Referring to, consulting with, coordinating with, and managing along with other healthcare providers my care and treatment.
- Determining my eligibility for health plan or insurance coverage, submitting bills, claims, and other related health information to insurance companies or others who may be responsible for paying for some or all of my healthcare.
- Performing various office, administrative and business functions that support my Provider's efforts to provide me with, arrange, and be reimbursed for quality, cost effective healthcare.

I also understand that I have the right to receive and review a written description of how the health clinic will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made, the information practices followed by the employees, staff, and other office personnel of DRHC, and my right regarding my health information.

I understand that I have the right to ask that some or all my health information not be used or disclosed in the manner described in the Notice of Privacy Practices.

By signing below, I agree that I have received, reviewed, and understand the information above. I understand I have the right to revoke this consent in writing, except to the extent that has already been used or information disclosed in reliance on this consent.

_____ _____ _____

Patient (or Representative) Signature Representative Name Date

I authorize DRHC to discuss my medical information with the following:

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Name: _____ Relationship:_____ Phone: _____

Revised 09/2025

DESCHUTES RIM
HEALTH CLINIC

Authorization to Leave a Message and/or communicate via Text, Email, Telehealth, or Voicemail Electronic Communications

Patient Name: _____ Birthdate: _____

Deschutes Rim Health Clinic (DRHC) understands that your privacy is important. We are required by law to maintain the privacy of Protected Health Information (PHI). There are limitations to ensuring confidentiality should you choose to communicate electronically by text, email, or voicemail.

- DRHC will not share text/emails outside of the agency without a Release of Information (ROI)
- For your protection, please limit electronic communications to brief messages and avoid providing detailed or sensitive information that may identify you. Do not use your social security number, last name, or date of birth
- Electronic communications cannot be guaranteed as secure as per HIPAA regulations
- Voicemails/answering machine messages consist of DRHC information, a call back number, and name to call back. Voicemails are also used to inform appointment times and dates. If you do not have voicemail which identifies you, we will be unable to leave any details.

Please INITIAL BELOW the level(s) of communication you are comfortable with:

I understand that the use of electronic communication means that my confidentiality cannot be guaranteed to HIPAA regulations. Knowing this, I give DRHC permission to communicate with me via:

_____ Text _____ Email _____ Voicemail

-OR-

_____ Other: I give DRHC **limited permission** to communicate with be **as described**: _____

_____

-OR-

_____ I DECLINE to give DRHC permission to communicate with me via any electronic communication means.

_____ I give DRHC permission to enroll me in telehealth appointments when available and for appropriate types of appointments

Signature: _____ Today's Date:_____

You have the right to revoke or amend this consent in writing at any time. This may require a new completed form.

Revised 09/2025