Advanced Internal Medicine Group, PC

PATIENT MEDICAL HISTORY FORM

Patient Name:____ **Date of Birth:**___________

Patient Maiden Name or Former Name:____

Date:____ **Physician:**________________________

How did you hear about AIM Health?____

Are there any specialists you see?____

PAST MEDICAL HISTORY: (Check conditions and illnesses for which you have been treated and include year of onset. List any other conditions which may not be included below.)

☐ No known medical problems
☐ Anemia___________________
☐ Anesthesia complications_____
☐ Anxiety___________________
☐ Arthritis__________________
☐ Asthma___________________
☐ Blood transfusion___________
☐ Cancer (list type below)______
☐ Cataracts_________________
☐ CHF______________________
☐ COPD_____________________
☐ Depression_________________
☐ Diabetes mellitus___________
☐ Emphysema________________
☐ Environmental allergies_______
☐ GERD_____________________
☐ Glaucoma_________________
☐ Heart murmur______________
☐ HIV/AIDS__________________
☐ Hyperlipidemia______________
☐ Hypertension_______________
☐ Kidney disease______________
☐ Meningitis_________________
☐ MI (Heart Attack)___________
☐ Nerve/Muscle disease_______
☐ Osteoporosis_______________
☐ Seizures__________________
☐ Sickle cell anemia__________
☐ Stroke/TIA________________
☐ Substance abuse___________
☐ Thyroid disease____________
☐ Tuberculosis/TB____________

Additional information/other history:____

____

PAST SURGICAL HISTORY: (Indicate year)

☐ No prior surgeries
☐ Appendectomy______________
☐ Brain surgery_______________
☐ CABG_____________________
☐ Cholecystectomy____________
☐ Colon surgery______________
☐ Cosmetic surgery___________
☐ C-section__________________
☐ Eye surgery________________
☐ Fracture surgery____________
☐ Hernia repair_______________
☐ Joint replacement___________
☐ Prostate surgery____________
☐ Hysterectomy______________
☐ Tubal ligation______________
☐ Small intestine surgery______
☐ Spine surgery______________
☐ Tonsillectomy______________
☐ Valve replacement__________
☐ Vasectomy_________________
☐ Breast surgery_____________

☐ Other surgeries and/or hospitalizations:____

____

FAMILY HISTORY: (Include history of diabetes, heart disease, hypertension, colon, breast, ovarian cancer, other cancers, autoimmune diseases, and age at diagnosis if known)

Relative	Alive/Deceased	Age	Health Problems
Mother	____________	_____	______________________________________
Father	____________	_____	______________________________________
Sister	____________	_____	______________________________________
Brother	____________	_____	______________________________________
Child(ren)	____________	_____	______________________________________

SOCIAL HISTORY:

Alcohol use: ☐ Yes ☐ No Number of drinks/frequency__________________________

Drug use: ☐ None ☐ Marijuana ☐Other______________________________________

Caffeine use: ☐ None ☐ 1-3 servings/day ☐ 4-6/day ☐ >6/day Type________________

Tobacco use: ☐ Never ☐Currently smoke __________ pack(s) per day for ____________years

☐ Previously smoked ______ pack(s) per day for ______________________ years

☐ Currently chew tobacco for __________________________________years

☐ Previously chewed tobacco for _________ years. Quit____________________

Marital status: ☐ Single ☐ Married ☐Partner ☐Widowed ☐Separated ☐Divorced

Children ☐ Yes ☐ No Ages___________________________________

Exercise: ☐ None Days per week______ Type_________________________

Occupation: ____

ALLERGIES:

Medication/food/environmental/drug allergy	Reaction
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PREVENTIVE SCREENING AND VACCINATIONS:

Last influenza vaccination____________________ Last pneumonia vaccination__________________

Last shingles vaccination_____________________ Last tetanus vaccination_____________________

Last colonoscopy__________________________ Last PSA/prostate exam_____________________

Last Bone density test______________________ Last pap smear____________________________

Last mammogram__________________________

OBSTETRIC/GYNECOLOGY HISTORY:

Number of pregnancies_____________________

Number of vaginal deliveries_________________ Number of cesarean sections_____________

Number of miscarriages_____________________ Number of abortions________________________

Last menstrual period______________________

Any pregnancy complications (i.e. gestational diabetes, pre-eclampsia)__________________________

____

History of sexually transmitted infection? ☐ Yes ☐ No Type/Year_____________________________

____

MEDICATIONS, VITAMINS, AND SUPPLEMENTS:

Name	Strength/Number taken and frequency

Advanced Internal Medicine Group, PC

FINANCIAL POLICY

Thank you for choosing Advanced Internal Medicine Group, PC (AIM Health) as your health care provider. We are committed to the successful treatment of your condition. Payment of your bill is considered part of your treatment and a clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities.

Changes:
It is your responsibility to notify our office of any patient information changes such as name, address, phone number, email, insurance information, etc.

Co-pays:
If you have a co-pay, you are responsible for remitting payment at the time of service. We accept cash, check, and credit cards.

Insurance:
AIM Health participates with many, but not all, insurance plans. It is your responsibility to contact your insurance company to verify that we participate with your plan. We will bill your insurance company and any secondary insurance company as a courtesy to you with a copy of your current insurance card. If we are unable to verify your insurance or you do not present with the correct insurance information you will be responsible for any and all charges incurred.

Paperwork Fee:
For patients that require help with paperwork requests such as physical forms, workplace notices, etc. that are separate from a scheduled office visit, we may charge a fee of $35.

Missed Appointments:
We will make every effort to give you a reminder at least 48 hours in advance prior to your appointment; however it is your responsibility to remember the appointment. We require a 24 hour notice for an appointment cancellation. Appointments that are missed and not previously canceled may be charged a 'No Show' fee of $50.

Uninsured Patients:
For New Patients and Physicals, we require a $225 deposit prior to the appointment; for all other office visit types, it is a $125 deposit. During the visit, you may have other services or procedures done in addition to the office visit itself, such as injections, and these will be at an additional charge. Office visits may also include x-rays, labs, and testing that are done by other healthcare facilities/providers, each of which have their own bills. Charges are not finalized until chart notes are complete.

Delinquent Accounts:
If you are not able to make payments as agreed and your account becomes delinquent, referral to a collection agency is our next step. If your account is referred for collections, there will be a $50 collection fee and any attorney fees per occurrence. Delinquent accounts are subject to dismissal from our practice. Personal checks that are returned from our bank for non-sufficient funds will be charged a $35 returned check fee.

Other Healthcare Providers:
Certain services we provide will generate bills from other healthcare facilities/providers, such as pathologists and/or reference laboratories. These bills are separate from our office and are your responsibility.

Authorization to Release Information:
In obtaining payment for services, I authorize my healthcare provider, AIM Health, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including but not limited to: my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. For further information regarding disclosure of health information, please refer to the Notice of Privacy Practices available in our office. If I have been referred by, or am referred to another healthcare provider, I authorize AIM Health, to release my medical information to this provider for continuing care.

By signing below, you have read, fully understand, and agree to this Financial Policy. You understand that you are financially responsible for all charges incurred for your medical treatment. Also, you have received and reviewed a copy of your physician's Notice of Privacy Practices.

_____________________________________ _______________________
Patient Signature or Authorized Signature Relationship to Patient

_____________________________________ ____/____/______ ____/____/______
Printed Name of Patient Date of Birth Date

Advanced Internal Medicine Group, PC

MEMBERSHIP AGREEMENT

Member: ____

Join Date: ____

Physician: ____

Advanced Internal Medicine Group, PC, an Oregon professional corporation doing business as "AIM" or "AIM Health" ("AIM Health"), is a medical practice that: a) is not an insurance plan or offers insurance, and b) provides additional services for which Member must pay private fees as outlined below. Members must still comply with AIM Health's Financial Policy.

Services. AIM Health offers the following Services to Members that are beyond Medicare or Member's health insurance plan ("Insurance") benefits:

- Same-day or next-day appointments at AIM Health's medical practice during business hours.
- Extended appointment times and visits as needed to accommodate individual circumstances.
- Member's physician available 24 hours per day, 7 days per week. If Member's physician is unavailable, another AIM Health physician will be made available.
- After-hours electronic and phone communications with AIM Health with same or next day response for evaluation and management to provide ongoing educational communication support, but specifically excluding electronic communication related to the office visit scheduling or following-up on an office visit covered by any applicable medical plan, or based on emergent medical needs.
- Subscription to online scheduling platform and integrated communications platform to manage personal health information.
- Assistance with administrative needs, such as scheduling of specialist appointments.

Participation in Services is limited to a select number of participants in order to preserve and retain the personal private character of health care services provided, and Member's annual renewal is at AIM Health's sole discretion.

Services Fee. The fee for Services ("Services Fee") is based on Member age. Members can pay monthly, quarterly, or annually. AIM Health offers a 5% discount if Member pays annually. Except for those Members with extenuating circumstances as determined by AIM Health, AIM Health requires that the Services Fee be paid via automatic payment; Members will sign the attached Member Dues Recurring Payment Authorization Form to pay by electronic funds transfer using a checking or savings account, or by credit card. Member must never submit to Medicare or any Insurance a request for reimbursement for the Services Fee.

Ages 18-39	$50 per month	$150 per quarter	$570 per year
Ages 40-59	$75 per month	$225 per quarter	$855 per year
Ages 60+	$100 per month	$300 per quarter	$1,140 per year

Member will receive an annual notice in the mail regarding changes to Services Fee based on age.

Insurance or Other Medical Coverage. This Agreement is not a substitute for health insurance or other health plan coverage (such as membership in an HMO). Member acknowledges that AIM Health has advised to obtain or keep in full force Member's health insurance policy(ies) or plans in order to cover Member and family members for healthcare costs. Member acknowledge that this Agreement is not a contract that provides health insurance, and this Agreement is not intended to replace any existing or future health insurance or health plan coverage that Member may carry.

In no event shall Services be deemed to include "access" to AIM Health, "care coordination" with other physicians covered or bundled with covered services, or emergency medical services.

Termination. This Agreement will commence on the Effective Date and will extend for one year thereafter, except that both Member and AIM Health shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination, upon giving 30 days prior written notice to the other party. This Agreement shall also terminate upon the death of the Patient. If the Agreement is terminated by written notice, AIM Health shall refund to Member, immediately upon the date of termination, the fee for the unexpired portion of the year in which the Agreement terminates, prorated based on the number of days during such year prior to the date of termination. Unless previously terminated as set forth above, at the expiration of the initial one-year term (and each succeeding one-year term), the Agreement will automatically renew for successive one-year terms upon the payment of the annual fee (or semi-annual fee, as the case may be) for the ensuing year. AIM Health may terminate this Agreement at any time should Member fail to timely pay the Services Fee or statements for health care services provided, or violate AIM Health policies or instructions communicated to Member.

Severability; Payment. If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.

Entire Agreement. This Agreement represents the entire agreement represents the entire agreement between the parties hereto with respect to the subject matter hereof and supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement, or promise relating to the subject matter of this Agreement shall be valid or binding.

Amendment. No amendment of this Agreement shall be binding on a party unless it is made in writing and signed by all the parties. Notwithstanding the foregoing, AIM Health may unilaterally amend this

Agreement to the extent required by federal, state, or local law or regulation ("Applicable Law") by sending Member 30 days advance written notice of any such change. Any such changes are incorporated by reference into this Agreement without the need for signature by the parties and are effective as of the date established by AIM Health, except that Member will initial any such change at AIM Health's request. Moreover, if Applicable Law requires this Agreement to contain provisions that are not expressly set forth in this Agreement, then, to the extent necessary, such provisions shall be incorporated by reference into this Agreement and shall be deemed a part of this Agreement as though they had been expressly set forth in this Agreement.

Assignment. This Agreement, and any rights Member may have under it, may not be assigned or transferred by Member.

________________________________	________________________________
Member Signature	Advanced Internal Medicine Group, PC

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: ________________________________ DATE OF BIRTH: ____/____/________

I AUTHORIZE:

____
Name of provider, facility, or individual that will SEND information

____
Street Address

____
City State Zip Code

(_____)_____________________(_____)____________

TO RELEASE TO:

Advanced Internal Medicine

9555 SW Barnes Rd Suite 255
Portland, Or 97225
Phone: (503) 908-1590 | Fax: (503) 723-2862

INFORMATION TO BE RELEASED: (Check all that are applicable)

□ All Information □ All Progress Notes □ Lab Reports □ Imaging Reports

□ Electrocardiogram (EKG) □ Allergy Records □ Immunization Records □ Other: ________________

SPECIAL AUTHORIZATION: (check all that are applicable and sign below)

By checking the appropriate boxes and signing below, you authorize the office to release any and all information regarding:

□ Alcohol □ Drugs □ Mental Health □ Sexually Transmitted Diseases □ HIV/AIDS

Signature:

If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

RECORDS FROM THE PERIOD: ______/______/______ to ______/______/______ or □ **ALL DATES**

PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)

□ Continued Medical Care □ Payment of Insurance Claim □ Legal □ Personal □ Other: __________________

I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

The requestor may be provided with a copy of this authorization.

PATIENT SIGNATURE:

DATE of REQUEST: ____/____/________

9555 SW Barnes Road, Suite 255
Portland, Oregon 97225
503-908-1590

Membership Service Fees Recurring Payment Authorization Form

Membership Service Fees are automatically deducted from your checking or savings bank account, or charged to your Visa, MasterCard, American Express, or Discover Card. You authorize regularly scheduled charges to your checking/savings account or credit card on the **25th of the month.** You will be charged the amount indicated below each billing period and a receipt for each payment will be made available to you. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

PLEASE COMPLETE THE INFORMATION BELOW

I hereby authorize AIM Health to automatically withdrawal from my account, as indicated below, to pay for membership Service Fees.

Authorized Full Name:______________________________

Billing Address:______________________________ Phone:______________________________

City, State, Zip:______________________________ Email:______________________________

MEMBERSHIP TYPE AND PAYMENT

Payment Frequency:			
Ages 18-39	$50 per month	$150 per quarter	$570 per year
Ages 40-59	$75 per month	$225 per quarter	$855 per year
Ages 60+	$100 per month	$300 per quarter	$1,140 per year

Check One: ☐ Monthly ☐ Quarterly ☐ Annually

Number of Members Covered:____________ Names of Member(s) Covered:______________________________

Birth Date(s) of Members Covered:______________________________

PAYMENT INFORMATION

Check One: ☐ Checking ☐ Savings ☐ Visa ☐ Amex ☐ Discover ☐ MasterCard

Name on Account:______________________________

Bank Name (Checking/Savings only)______________________________

Bank Routing # (Checking/Savings only)______________________________

Bank Account # (Checking/Savings only)______________________________

Credit Card # (Visa, Amex, Discover, MasterCard only)______________________________

Card Expiration:_____/______Card CVN:_____/______

Authorized Signature:______________________________ **Date:**________________

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify AIM Health in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that AIM Health may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.