

CLINIC REGISTRATION INSTRUCTIONS

Please read this important information carefully

***All patients must complete a registration packet.**

These forms are part of your permanent patient record with Compassion Center Clinic. Please read this registration thoroughly and be sure to answer each question as completely and as accurately as possible. Please include a method of payment with completed registration. We accept cash, checks, money orders, and credit cards. Make out all checks and money orders to "Compassion Center".

STEPS TO COMPLETE YOUR REGISTRATION PACKET:

1. Complete and sign the **Renewal Clinic Registration form**.
2. Complete, date, initial and sign the **Authorization for Release of Medical Records form** included in this packet unless you are bringing records in. For returning patients, we require at least one medical record from **within the past year** documenting your qualifying condition. New patients, please provide at least two years of medical history.
***VETERANS:** Fill out a **VA Authorization for Release of Medical Records**, which can be found at our website, or requested at the front desk.
3. **Turn your registration packet in to Compassion Center.**
4. The medical records staff at Compassion Center will fax or mail the Authorization for Release of Medical Records form to the doctor or medical facility you have indicated. Once we have received and reviewed your medical records, we will call to schedule an appointment for the earliest available clinic. It may take 2-4 weeks for your doctor to send records to us.

Please review our **Privacy Policy** (available at our website and office).

FEES FOR ALL PATIENTS:

- **\$25 registration fee:** must be paid before registration can be processed.
- **\$150 Doctor Appointment and Physical Exam:** must be paid before or on the day of your appointment.

All fees are non-refundable.

Make checks/money orders payable to Compassion Center.

We charge \$35 for returned checks. Compassion Center fees are subject to periodic review and change.

We charge \$30 for a missed appointment due to no-show or less than 24-hour notice

NOTE: Registering with Compassion Center as a patient is not the same as registering or renewing with the State of Oregon for the OMMP. The state requires an application and payment of a fee for registering with the OMMP. For current information and fees call Oregon Medical Marijuana Program at 971-673-1234.

NEW CLINIC REGISTRATION

Last Name _____ First _____ MI _____ DOB ____/____/____

Phone ____ - ____ - ____ Mailing Address _____ Street _____ Apt# _____ City _____ State _____ Zip _____

Email _____ Emergency Contact _____ Phone ____ - ____ - ____

 I am a renewing patient with OMMP but new to the Compassion Center

My qualifying condition as I understand is: _____ _____ _____ _____ My condition was diagnosed on or about: _____ Month Year At (clinic/hospital name) _____ _____ Address City State Zip Phone ____ - ____ - ____	<h4 style="text-align: center;">PRESENT MEDICAL CONDITION</h4> Treatments, surgery, medication, or alternative care prescribed for your condition: _____ _____ _____ Do you plan to use MMJ for another medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe: _____ _____
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 How did you hear about the Compassion Center? Dr. Referral Friend/Family Brochure Eugene Weekly
 Internet Boomer & Senior News Cannabis Connection Other: _____

I would like to establish a relationship with a physician who will work with me and my choices of treatment. I would like to participate in the Compassion Center Clinic Program. The information contained in this application is true and accurate to the best of my knowledge. I also have had an opportunity to review Compassion Center's Privacy Policy.

Patient signature _____ **Date Signed** _____

METHOD OF PAYMENT: VISA MASTERCARD DISCOVER (circle one)

 My credit card number is: _____ - _____ - _____ - _____ Expiration Date: ____/____
 Amount Paid: _____ Signature: _____ 3-Digit Code: _____

For Staff Use Only

Appointment Date: _____ Scheduled By (Initials): _____	COPY ID HERE										
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Date Paid _____</td> <td style="width: 50%;">Date Paid _____</td> </tr> <tr> <td>Amount \$ _____</td> <td>Amount \$ _____</td> </tr> <tr> <td>Receipt # _____</td> <td>Receipt # _____</td> </tr> <tr> <td>Initials _____</td> <td>Initials _____</td> </tr> <tr> <td>Cash/Check/Credit Card _____</td> <td>Cash/Check/Credit Card _____</td> </tr> </table>	Date Paid _____	Date Paid _____	Amount \$ _____	Amount \$ _____	Receipt # _____	Receipt # _____	Initials _____	Initials _____	Cash/Check/Credit Card _____	Cash/Check/Credit Card _____	
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MEDICAL HISTORY

Today's Date _____/_____/_____

 Name _____ DOB _____
Last First MI Month Day Year

 Gender: Female Male Relationship status: Single Married Partner Widowed Divorced

 Years of Education: _____ Military: No Yes, Veteran for _____ # of years; Medical Discharge? Yes No

FAMILY MEDICAL HISTORY	FAMILY MEMBERS																																																						
Do you have any blood relatives who have or have had any of the listed conditions? Please check all that apply. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"></td> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 15%; text-align: center;">Relationship</td> <td style="width: 50%;"></td> </tr> <tr> <td>Cancer</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>Epilepsy</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>Diabetes</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>Heart Disease</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>HIV/AIDS</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>Kidney Disease</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>Liver Disease</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>Multiple Sclerosis</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> <tr> <td>TB</td> <td style="text-align: center;">_ _</td> <td style="text-align: center;">_ _</td> <td></td> <td></td> </tr> </table>		Yes	No	Relationship		Cancer	_ _	_ _			Epilepsy	_ _	_ _			Diabetes	_ _	_ _			Heart Disease	_ _	_ _			HIV/AIDS	_ _	_ _			Kidney Disease	_ _	_ _			Liver Disease	_ _	_ _			Multiple Sclerosis	_ _	_ _			TB	_ _	_ _			If Living		If Deceased		
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	Health				Cause of Death, if Known	Age at time of death																																																	
	Age	Good	Fair	Poor																																																			
	Mother																																																						
	Father																																																						
	Sisters and Brothers																																																						
	Children																																																						

PERSONAL MEDICAL HISTORY

Do you have or have you had any of these medical conditions? Please check all that apply.

___ Glaucoma ___ Emphysema ___ TB ___ Respiratory disease ___ Asthma ___ Cancer ___ Leukemia ___ Diabetes ___ Stomach Ulcers ___ Kidney Disease ___ Hepatitis or Liver disease ___ Congenital Heart Problem	___ Thyroid Problems ___ Heart Problems ___ Blood Pressure Problems ___ Stroke ___ Epilepsy ___ Multiple Sclerosis ___ Arthritis ___ Rheumatism ___ Migraines ___ Alzheimer's Disease ___ Nervous Breakdown ___ Mental/Emotional Illness	___ Are you pregnant? ___ Breast Feeding? ___ Other _____ Last Chest X-Ray _____ Last Mammogram _____ Surgeries, accidents, injuries, medical conditions, or diseases that required hospitalization in the past five years. _____ Year _____ _____ Year _____ _____ Year _____ _____ Year _____ _____ Year _____
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All Compassion Center records are confidential and secure. Compassion Center will not share these records with any individual or organization without written permission from the patient.



AUTHORIZATION for RELEASE of MEDICAL RECORDS:

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Please forward these records to:

Compassion Center

2055 W. 12th Ave

Eugene, Oregon 97402

Phone: 541.484.6558 Fax: 541.484.0891

Please MAIL if 10 or more pages

Please FAX if less than 10 page



◇ NEW PATIENTS:

◇ RENEWAL PATIENTS :

If the information to be disclosed contains the types of records or information listed below, additional laws relating to the use and disclosure of that information may apply. I understand and agree that this information will be disclosed if I initial the applicable space next to that type of information.

⇒ Mental Health ⇒ Drug/Alcohol ⇒ HIV/AIDS ⇒ Genetic Testing

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

Refusal to sign this release will not affect ability to receive health care, services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. To revoke this authorization at any time, submit a written request to:

Compassion Center, 2055 W. 12th Avenue, Eugene OR 97402

The only exception is when action has already been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

My signature below acknowledges that I understand and accept this release of information.

Printed Name: _____

Signature: _____ Date: _____