a private & independent health service
5111 SE Lake Rd, Milwaukie, OR 97222
phone / text: 503.461.0591
fax: 503.386.3233

New Patient Information

Name (First, Middle, Last)	Date of Birth (Month / Date / Year)
Address: Preferred phone #: Email Address:	Emergency Contact* or Guardian/Parent*: *Ok to coordinate care & share patient health info? YES / NO *OK to share mental health information? YES / NO
Primary Care Office: Preferred Pharmacy:	Insurance Name: Policy # / Member ID: Insured Name & Date of Birth: Patient relationship to insured: (self)

Patient Preference on Communications (Email, SMS, Spruce app)

I hereby consent and state my preference to have my physician, **Dr. Edward Lin**, and other staff at **Interstitium Health** communicate with me by email and/or standard SMS messaging and/or Spruce secure communication app regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

I further understand that any telephone voicemails that I leave for **Interstitium Health** will be transcribed automatically by a third party for use by **Interstitium Health** and that this process is not guaranteed to be secure, though effort is made to make it so.

Name / Signature:	Date:
Guardian Name / Signature:	Date:

Patient Agreement and Consent for treatment

If you have any questions or concerns about the following items – please contact us directly prior to signing.

___ I understand that Interstitium Health / Dr. Lin does not manage chronic pain nor chronic daily use of benzodiazepines / sedative-hypnotic medications (such as Ambien) nor muscle relaxants (such as Soma).

___ I understand that Interstitium Health / Dr. Lin does not prescribe controlled medications on the first visit.

___ I agree that during any and all telemedicine visits (either video or audio), I will be physically within the state of Oregon.

___ I agree to pay Interstitium Health directly for care at the time of service for any fees due - such as insurance co-pays or services not covered by insurance.

__ I understand and agree that Interstitium Health / Dr. Lin will make every effort to respond to communications in a timely manner but I will seek urgent or emergency services as appropriate if Dr. Lin is not immediately available.

___ I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided to me by Interstitium Health. This may include outside laboratory testing or imaging done.

___ I understand that Interstitium Health / Dr. Lin is currently not managing MVA or worker's compensation cases.

___ I understand that the primary method to communicate with Dr. Lin is during scheduled office visits. Outside of visit communications may be addressed via email, phone calls, or secured app (such as Spruce Health app).

___ I understand that while I may use email and SMS / text messaging to communicate with Interstitium Health / Dr. Lin - these options may not be HIPAA-compliant and is not a completely secure form of communication.

___ I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Interstitium Health / Dr. Lin. I understand that the practice of medicine is not an exact science and that no guarantee has been or can be made as to the resu lts of the treatments or examinations.

___ I consent to the use and disclosure of my/the patient's protected health information for treatment and health care operations consistent with the Interstitium Notice of Privacy Practice (namely with labs or imaging facilities, consultant clinicians).

For patients with an outside primary care physician:

___ I understand that Interstitium Health / Dr. Lin is providing adjunctive or interval care and is not meant to take the place of health insurance or a regular primary care physician.

___ I agree that if any urgent after-hours medical issues occur, I will contact my primary care provider and/or go to urgent care or the emergency room.

Name / Signature:	Date:
Guardian Name / Signature:	Date: