Compassion Center
2055 W. 12th Avenue. Eugene OR 97402 Phone (541) 484---6558 Fax (541) 484---0891

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.
   *<u>**VETERANS**</u>: 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.

All Compassion Center records are confidential and secure. Compassion Center will not share these or any records with any individual or organization without the written permission from the patient.
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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_____-_____-______

PRESENT MEDICAL CONDITION

Treatments, surgery, medication, or alternative care prescribed for your condition: _________________________
____
____

Do you plan to use MMJ for another medical condition?
☐ No ☐ Yes
If yes, please describe:_________________________________
____

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

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

Do you have any blood relatives who have or have had any of the listed conditions? Please check all that apply.

	Yes	No	Relationship
Cancer	__	__	______________________
Epilepsy	__	__	______________________
Diabetes	__	__	______________________
Heart Disease	__	__	______________________
HIV/AIDS	__	__	______________________
Kidney Disease	__	__	______________________
Liver Disease	__	__	______________________
Multiple Sclerosis	__	__	______________________
TB	__	__	______________________

FAMILY MEMBERS

	If Living				If Deceased	
		Health				
	Age	Good	Fair	Poor	Cause of Death, if Known	Age at time of death
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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AUTHORIZATION for RELEASE of MEDICAL RECORDS:

/BNF PG 1BUJFOU #

3&26&45/(3&$034 '30.

1IZTJDJBO 'BDJMJUZ

4USFFU "EESFTT

1IPOF 'BY

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*

Continuing Care

(BEGIN DATE) (END DATE)

◊ 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: ________________

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