Yamhill Valley Surgical Center Patient Registration

Please Fully complete

Name:_____ ***Date of Birth***:_____
Last First M.I.

Address:_____
Street address – and/or post office box City State Zip
(if you receive your mail at a PO Box, please include this information - thank you)

*Home Phone:*_____ *Cell Phone:*_____ *Work phone*_____*ext*____

*E mail:*_____ *Social Security #:*_____ *Sex: Male / Female*

*Primary Care MD:*_____ *Marital Status: Single / Married / Widowed / Other*

*Employer:*_____*Full time Y/N*____ *Student Y/N*_____

*Emergency Contact:*_____*Phone:*_____

*Preferred Pharmacy:*_____*Phone:*_____

Responsible Party:

*Name:*_____ *Phone:*_____
Relation to patient: (circle) Self / Spouse / Parent(s) / Other

Address:_____
Street City State Zip

Primary Medical Insurance: * If you are enrolled with a Medicare Advantage plan, provide the Advantage plan name – ***OR*** - If you are enrolled on the Oregon Health Plan, indicate if you are on Open Card, or Managed care, i.e; YCCO, Marion Polk Community Health, CareOregon, etc.

Ins.Carrier Name:_____ID#_____Group#:_____

Carrier Address:_____

Subscriber: Self / Spouse / Parent (s) / Other ***Subscriber Name:***_____ ***DOB:***_____
(Important! Please complete the line above)

Secondary Medical Insurance:

*Ins.Carrier Name:*_____*ID#*_____*Group#*_____

Carrier Address:_____

Subscriber: Self / Spouse / Parent (s) / Other ***Subscriber Name:***_____ ***DOB:***_____
(Important! Please complete the line above)

Please Sign Below:

Authorization for Treatment, Financial Agreement, Advanced Directive Notice

I have been offered a copy of the Oregon Advanced Directive.

I have received a copy of the Patient Rights and Physician Financial Interest Disclosure.

Patient/Responsible Party Signature X_____Date X_____

*** * * Office Use * * ***

Procedure:_____ Date_____
Insurance Auth#_____
Referring MD:_____ Reason for Procedure:_____

***** Please return COMPLETED paperwork NO LATER than 48 hours prior to your procedure, along with your insurance card, to avoid cancellation of your appointment. Thank you! *****

Updated 12/1/2025

Medical Information

Yamhill Valley Surgical Center

To facilitate your visit, please provide the following information:

Name: _____ Age:_____

List any ***surgeries*** you have ever had:

_____
_____
_____
_____
_____

List any ***medical conditions*** for which you are currently under treatment:
(i.e. high blood pressure, diabetes, heart disease, asthma, etc.)

_____
_____
_____
_____

Please indicate if you need ***mobility assistance*** or use a wheelchair:
All patients must be able to self-transfer to a hospital bed, or the procedure must be performed at the hospital

_____
_____
_____

Please list any ***allergies*** you have to medications and the reaction:
(for example, penicillin –rash)

_____
_____
_____
_____

Please indicate if you use ***tobacco***, ***alcohol***, or ***recreational drugs***:

_____
_____
_____

Please indicate your understanding of why you are having this procedure:

_____
_____
_____

Medication Reconciliation Form

(Forma por Medicamentos)

Yamhill Valley Surgical Center

503-474-0650

Name (Nombre) _____ Procedure date _____

(Fecha de procedimiento)

Please list all of your medications, the dosage, and number of times used per day. Include over the counter medicines and supplements. (Por favor lista de todos sus medicamentos, dosis, y número de veces por día. Incluyen los suplementos y vitaminas.)

Leave blank (No escribe)

Drug Medicamento	Dose (mg) Dosis (mg)	Times/day Veces/día	

Post-procedure instructions (Instrucciones después del procedimiento):

- Resume all previous medications (Reanude todos sus medicamentos)
- Stop these medications (Pare estos medicamentos): _____
- Hold for ___ days, then resume (Pare durante___ días, luego reanude): _____
- Add the following medications (Añada estos medicamentos): _____

_____

_____ _____ _____

Nurse signature Physician signature Time

Release of Information

I hereby authorize the release of any and all chart information to my insurance companies.

By reading this I have been informed that my information may be sent to primary care providers, hospital staff, laboratory staff, billing or collection agencies and cancer registry staff as needed for my medical care and for billing purposes.

I also understand that J. Scott Gibson M.D., P.C. and Yamhill Valley Surgical Center, Inc. and their staff will make reasonable efforts to protect my privacy and to ensure that no unauthorized person has access to my personal information.

Phone messages (including appointments and lab results) may be left on message machine at _____
Area code and phone number

I have read and understand the above:

✕ _____
Patient signature Date

I hereby authorize the release of my information to:

_____
Name

This may include chart notes, lab and radiology results, treatment plan, insurance and account information. This release will not include any personal social security or driver's license information.

✕ _____
Patient signature Date

Billing Notice

For your procedure, you will be billed by two entities, **Yamhill Valley Surgical Center, Inc.** for provision of procedural services, and your surgeon, **Dr. J. Scott Gibson**, for provision of professional medical services. You and your insurance will therefore receive two separate bills. If biopsies are taken, you and your insurance will also receive a bill from a pathology lab that has no financial association with Yamhill Valley Surgical Center, Inc. or your surgeon.

Assignment of Insurance Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits for which I and/or my dependents are entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment directly to **Yamhill Valley Surgical Center, Inc. and J. Scott Gibson, MD., PC.**

Authorization to Release Information

I hereby authorize **Yamhill Valley Surgical Center, Inc. and J. Scott Gibson, MD., PC.** to:
(1) release any information necessary to insurance carriers including Medicare and Medicaid regarding my illness and treatments; (2) process insurance claims generated in the course of examination and treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

Financial Responsibility

I have requested medical services from **Yamhill Valley Surgical Center, Inc. and J. Scott Gibson, MD., PC.** for myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

I further understand that fees are due and payable upon receipt of a billing statement and agree to pay all such charges incurred in full immediately upon presentation unless other arrangements are made in advance.

A photocopy of these assignments shall be valid as the original.

Patient (please print) _____

Parent/Guardian/POA (please print) _____

Signature X _____ Date X _____

Patient Rights and Responsibilities & Financial Interest Disclosure

Yamhill Valley Surgical Center

Patient Responsibilities

The patient or their representative is responsible to:

Be respectful to staff and others in the facility.

Provide complete and accurate information to the best of his/her ability about his/her health, medications (including over-the-counter medications and supplements), and any allergies or sensitivities.

Follow the treatment plan prescribed by his/her provider and participate in his/her care.

Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by the provider.

Accept financial responsibility for any charges not covered by his/her insurance.

You are requested to bring a copy of your advanced directive to the procedure, if you have one.

Patient Rights

Information disclosure. You have the right to accurate and easily-understood information about your procedure, health care professionals, and health care facility. If you speak another language, have a physical or mental disability, or just don't understand something, help should be given so you can make informed health care decisions.

Participation in treatment decisions. You have the right to know your treatment options and take part in decisions about your care. Parents, guardians, family members, or others that you select can represent you if you cannot make your own decisions.

Advanced Directive. In accordance with facility policy, you may receive, upon request, an Advanced Directive allowing you to specify your medical care choices and assign a health care representative in the event that you are unable to make decisions for yourself. If you want information on Oregon's Advance Directive law, you may find it at http://www.oregon.gov/DCBS/SHIBA/advanced_directives.shtml If you make your wishes about resuscitative care known to the staff at Yamhill Valley Surgical Center, we will honor your request to the best of our abilities.

Respect and non-discrimination. You have a right to considerate, respectful care from your doctors, health plan representatives, and other health care providers that does not discriminate against you. You have the right to be free from all forms of abuse or harassment.

Confidentiality of health information. You have the right to talk privately with health care providers and to have your health care information protected. You also have the right to read and copy your own medical record. You have the right to ask that your doctor change your record if it is not correct, relevant, or complete.

Billing. All patients have the right to examine and receive an explanation of their bill, regardless of the source of payment.

Complaints and appeals. You have the right to a fair, fast, and objective review of any complaint you have against your doctor, health care facility or other health care personnel. This includes complaints about waiting times, operating hours, the actions of health care personnel, and the adequacy of health care facilities. If you have a complaint or grievance, you may submit it verbally or in writing to any staff member and the matter will be taken to the Quality Assurance Committee within two weeks. You will be informed of the outcome of the evaluation of your complaint and, if appropriate, any remedial action taken.

Privacy and care. You have the right to personal privacy and to receive care in a safe setting.

To register complaints you may contact the Office of the Medicare Ombudsman at

http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html

You may also contact the Oregon Department of Public Health Division--Healthcare Regulation and Quality Improvement, 800 NE Oregon Street, Suite 465, Portland, OR 97232, 971-673-0540. Email: mailbox.HCLC@odhsoha.oregon.gov

Physician Financial Interest Disclosure

Your procedure is scheduled to be performed at Yamhill Valley Surgical Center, located at 2375 NE Cumulus Ave., McMinnville, Oregon. This facility is owned exclusively by Dr. Scott Gibson. You have the right to obtain healthcare services at any hospital or surgical center and from any provider of your choice.