Salem Office
891 23rd St NE
Salem, OR 97301
Phone: (503) 364-2181
Fax: (503) 364-0364

2026
Welcome to Childhood Health Associates of Salem!
New Patient Packet

Childhood Health Associates of Salem provides timely, high quality and patient centered care for children and teens up to 18 years of age. We provide care for:

- Your child when ill
- Provide well child visits and vaccines
- Manage chronic illnesses, such as asthma
- Manage mental health conditions, such as ADHD, anxiety and depression

Our provider teams consist of pediatricians, pediatric nurse practitioners and physicians assistants.

Other members of the care team for your child are nurses who can answer phone questions, providing education about chronic medical problems.

There are also behavioral specialists who are part of the care team and can help with behavioral issues.

Lastly, for children with complicated medical needs, there are nurse case managers who can help with care plans and equipment needs, etc.

Our hours are 8am - 8pm Monday – Thursday, 8am – 5:30pm Friday with a same day urgent care clinic, Saturday from 9am - 12pm. Advice nurses are available 24/7 through our main office number.

Let us know if you have any questions!

Patient Registration Form

Patient's legal name: _____**Middle Initial**____**Last:**_____

DOB:_____ **Sex** Male Female **Preferred Pronoun**_____ **Language**_____

Patient's Address**:**_____City_____State_____Zip_____

Circle any that apply

Ethnicity	**Race**	
Hispanic or Latino	White	American Indian or Alaskan Native
Not Hispanic or Latino	Native Hawaiian or Pacific Islander	Decline
Unknown	Black or African American	Other
Decline	Asian	

***Primary Parent/Guardian legal name**:_____

DOB:_____ Phone number:_____ SSN:_____

Address: _____City_____State_____Zip_____

Relationship to patient (bio parent, step parent, guardian etc): _____

Resides with patient: Yes No Email:_____

Sign up for patient portal? Yes No (If yes, you will receive an email invite at the email address provided above)

***Secondary Parent/Guardian legal name**:_____

DOB:_____ Phone number:_____ SSN:_____

Address: _____City_____State_____Zip_____

Relationship to patient (bio parent, step parent, guardian etc): _____

Resides with patient: Yes No Email:_____

Sign up for patient portal? Yes No (If yes, you will receive an email invite at the email address provided above)

Emergency Contact (someone other than parent or guardian)

Name:_____ Phone number:_____ Relationship to Patient_____

I hereby give permission to Childhood Health Associates of Salem to treat the above named child for routine care and in my absence, to administer to them emergency care as deemed necessary by the physician in attendance. I hereby authorize Childhood Health Associates of Salem to release medical information necessary to insurance companies and similar organizations in order to process my insurance claims. I understand that I am financially responsible for all the charges incurred whether those charges are covered by insurance or not. I authorize insurance benefits to be paid directly to Childhood Health Associates of Salem.

Signature_____ **Date**_____

Medical History

Patients Name: _____ **DOB**:_____

Is your child allergic to any drugs or medicines? ___Yes ___No Which ones?_____

Any problems during the pregnancy or delivery for this child? ___Yes ___No Describe: _____

Was this child born early? ___Yes ___No Gestational Age: _____ Birth Weight:_____

Was your child born or immunized outside of the USA? ___Yes ___No Where? _____

Has your child ever had surgery? ___Yes ___No What for? _____

Has your child ever been hospitalized overnight? ___Yes ___No Describe: _____

Has your child ever had any chronic diseases? ___Yes ___No Describe: _____

Has your child ever had any serious injury? ___Yes ___No Describe: _____

Has your child been receiving any medicine or treatment for longer than 1 month? ___Yes ___No

Describe:_____

Is there a smoker in the home? ___Yes ___No

Has your child ever had...

___ADHD/ADD or behavior problems ___Allergies /"hay fever" ___Asthma ___Birth defects ___Bladder

___Kidney problem ___Cancer ___Chickenpox ___Autism ___Depression ___Anxiety ___Diabetes

___Eczema ___Hearing problems ___Heart disease or problem ___High blood pressure

___Learning disability or problem ___Meningitis ___Obesity ___Pneumonia ___Seizures/Epilepsy

___TB disease or exposure ___Vision problems

Is there any history among the parents or siblings of patient of...

___ADHD/ADD or behavior problems ___Allergies /"hay fever" ___Asthma ___Birth defects

___Bladder or Kidney problem ___Cancer ___Chickenpox ___Autism ___Depression ___Anxiety ___Diabetes

___Eczema ___Hearing problems ___Heart disease or problem ___High blood pressure

___Learning disability or problem ___Meningitis ___Obesity ___Pneumonia ___Seizures/Epilepsy

___TB disease or exposure ___Vision problems ___Smoker indoors ___Smoker outdoors

Anything else you would like to share about your child's health:

_____

_____

_____

Printed Name_____ **Signature:**_____

Relationship to patient _____ **Date**_____ Rev Aug 2024

Rev Nov 2025

APPOINTMENT ATTENDANCE AGREEMENT

In our ongoing effort to provide exceptional health care access, Childhood Health Associates of Salem is providing you with our expectations regarding appointment cancellations and no shows.

For the provider to make the most of your scheduled appointment, patients are expected to arrive on time. Patients arriving 10 minutes late may be considered a no show and may be unable to be seen.

We ask that in the event you need to cancel your appointment, you notify the clinic 24 hours in advance. Patients calling less than two (2) hours' notice will be considered a no show.

1. After the first no show, the patient will be notified in writing of the consequences of no showing or arriving late to their appointment.
2. After the second no show, the patient will be notified in writing of the consequences of no showing or arriving late to their appointment.
3. After the third no show the patient may be dismissed from the practice.

I have read and agree to the Appointment Attendance Agreement.

Patient Name: _____ **DOB:** _____

Signature of Parent/Guardian or patient if 18 yrs or older: _____

Date: _____

- You are entitled to a copy this document after you have signed it.

VACCINE POLICY AGREEMENT

Childhood Health Associates of Salem requires all patients to have received at least **one dose each of MMR and varicella, as well as three doses of DTaP,** by age 24 months to remain in our practice. While we strongly advocate for the AAP/ACIP vaccine schedule, as it provides the best protection for children, we have minimum vaccine requirements.

Vaccines are highly effective in protecting children from diseases like measles, chickenpox, and pertussis, among others. They are safe for routine use and are typically covered by insurance as part of preventive care. Additionally, the federal Vaccines For Children program supplies vaccines for children on Medicaid (OHP) or without insurance. Our clinic carries and administers all routine childhood vaccines, and our patients have some of the highest vaccination rates in the state, reflecting our community's commitment to vaccination. Given that we care for a significant number of children with special health care needs, protecting them from vaccine-preventable diseases is particularly important.

If you choose not to vaccinate your child according to the minimum schedule and there is no valid medical reason, we will ask that you find another primary care provider. Please understand that we do not keep lists of healthcare providers who discourage vaccination, nor would we recommend them.

I acknowledge that my provider will discuss and recommend age-appropriate immunizations or whenever indicated.

Patient Name: _____ **DOB:** _____

Signature of Parent/Guardian or patient if 18 yrs or older: _____

Date: _____

- You are entitled to a copy this document after you have signed it.

Childhood Health Associates of Salem
Financial Policy

Patient name:_____ DOB:_____

We are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

All payment is expected at the time of service
Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Our insurance contracts do not allow us to waive co-payments. You are responsible for knowing your coverage and benefits; our recommendation for treatment does not constitute a guarantee of coverage. Appointments after 5:00pm or on weekends or holidays are subject to a small additional charge that may or may not be paid by your insurance.

Payment Method

Childhood Health Associates of Salem accepts cash, personal checks (in-state only), money orders, VISA, and MasterCard. Payments can be made online once you have received a statement and an online account is created.

Returned Checks
All returned checks will be assessed a $25.00 service fee; we reserve the right to require payment by cash or credit card for accounts with a history of returned checks.

Outstanding Balances
Effective July 1st, 2015 the minimum monthly payment required for outstanding balances will be as follows:
For balances $300.00 or under a minimum of $25.00 per month
$300.00-600.00 a minimum of $50.00 per month
$600.00-900.00 a minimum of $75.00 per month
$900 and above a minimum of $100.00 per month

We also offer the opportunity to set up automatic monthly payment plans for outstanding balances, using a valid credit card. We will continue to provide medical services as long as timely payments continue to be made on a monthly basis. Accounts with outstanding balances that show no progress for 120 days will be sent to collections and will be terminated from the practice as well as any siblings associated with the account. Patients that have been terminated from the practice for non-payment may be reinstated to the practice, provided the balance is paid in full. There is also a reinstatement fee of $25 per child, with a max of $100 per family. Please note that any family sent to collections for a second time will not be reinstated.

Insurance

Updating information
You are responsible to inform us of updated and accurate insurance information for us to properly bill insurance on your behalf. Insurance information must be updated as soon as possible for each patient in the family as each patient has a separate account.

Primary Insurance
We bill participating insurance companies as a courtesy to you. You are required to pay your copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible to be sure all charges are paid, whether by you or by your insurance carrier.

Secondary Insurance
We do bill secondary insurance companies with whom we have a current contract as a courtesy to you. While we do contract with most area insurance plans, there exists no mechanism for us to bill plans with whom we do not contract. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. If you feel this is in error please contact your secondary insurance company.

Signature on back of page

Special Circumstances

Behavioral Health Services
If your child receives Behavioral Health services at the time of a visit, additional charges may apply. It is your responsibility to understand your health insurance benefits as they relate to Behavioral Health services. If your health insurance does not cover all or a portion of such visit, you will be responsible for payment.

Motor Vehicle Accidents
Patients involved in a motor vehicle accident or similar situation must provide information regarding the responsible insurance so that we may bill that insurance as a courtesy. We will need the insurance name, mailing address, phone number, and the claim number in order to provide this service. Failure to submit this information to us prior to the office visit may result in charges to the patient's account

Domestic Relations Issues
In the case of parental divorce or separation, the parent authorizing treatment for the child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or a portion of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Self pay
Patients not covered by insurance are considered "self pay" and are required to make a minimum payment on their account at the time of service unless other arrangements have been made. If you are not covered by insurance, please contact our billing department as soon as possible to make arrangements for a payment plan.

If you need assistance or have questions, please contact our billing office between 8:00 a.m. and 4:00 p.m., Monday through Friday at 503-364-0227.

Refunds

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

Missed Appointments/Late Cancellations
Missed appointments represent a cost to us, to you and to the patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Three(3) or more missed appointments without at least 24 hours notice to our staff may result in discharge from the practice.

Release of Benefits and Information:
I authorize my insurance benefits to be paid directly to the provider. I authorize the release of any information required to process the claim for payment. I understand that if my child has a well child appointment, and there is an absence of coverage, a minimum payment of $100 shall be made toward the full charge of the visit. Additional charges may apply to after hours, weekends and holidays. If your health insurance does not cover a provided service you will be responsible for payment.

Signature of insured or authorized representative (must be 18 years or older):

Signature _____

Name of person signing(print): _____

Date: _____

HIPAA Form A: Acknowledgment and Consent

Patient Name: _____ Patient DOB: _____

I understand that Childhood Health Associates of Salem under specific circumstances will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Childhood Health Associates of Salem may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other health care providers who participate in patient's health care for treatment purposes.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physicians efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Childhood Health Associates of Salem will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices.

I understand that a copy or a summary of the most current version of This Practices Notice of Privacy Practices was made available for me to review in addition to be posted in waiting/reception area and available on the website at http://www.childhoodhealth.com .

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests. (To make such a request, ask for a Form H Request for Restriction on Use/Disclosure of Medical Information.)

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices

Signature:_____ **Date:**_____

(Patients legal representative or patient if 18ys or older)

Representatives Authority: ____Parent, _____Legal Guardian, ____Foster/Resource (DHS) ____ Patient (18 yrs or older)

Other:_____

STOP! If you child is a new born – NO NEED TO FILL OUT THIS FORM
ONLY fill out if medical records are needed from previous office

891 23rd Street, N.E. Salem, OR 97301 - Ph# (503) 364-2181 - Fax# (503) 364-0364

Form B: Authorization to Use/ Disclose, Share or Receive Health Information

I authorize Childhood Health Associates of Salem (CHAOS) to use and disclose/Receive or Share a copy of the specific health and medical information described below regarding:

Name of Patient: _____ DOB: _____

To Receive Records:

All Records from Previous Provider_____Specific Records from Previous Provider_____

To release Specially Protected Information, please initial w here appropriate:

_____Mental Health (inc. ADHD/ADD), if patient over 14, they must initial

_____Alcohol/Chemical Dependency, if patient over 14, they must initial

_____Sexually Transmitted Diseases, patient must initial

_____Birth Control, patient must initial

_____ Genetic Information

_____HIV/AIDS

_____
Signature of person initialing above

From :_____
(Name, address and fax number or Email address Required)

Phone # :_____

Please check which format you need your records; For Paper___ For PDF____ For Electronic ePHI ____ for both PDF & ePHI ____

for the purpose of:_____
(Describe each purpose of disclosure or state "at the request of the individual" if this authorization is initiated by the individual and the individual does not, or elects not to, provide a statement of purpose.)

Childhood Health Associates of Salem
891 23rd Street, N.E.
Salem, OR 97301

Patient: _____ DOB:_____

Your health care and payment for that health care cannot be conditioned upon receipt of this signed Authorization unless your health care or treatment is for the purpose of: 1. Creating health information about you to be disclosed to a third party; or 2. For the purpose of research. You have the right to revoke this Authorization at any time, provided that you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Ingrid Hogenstad at 891 23rd St. NE, Salem, OR 97301 t hat identifies the date you signed this Authorization, the recipient of the information identified in this Authorization, and states that you are revoking this Authorization.
This Authorization will expire on the earlier of either_____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure of the above-described purpose.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

Foster parents: Please initials only!
By:_____
Date:_____
(Patient's foster parent)

Note: If initialed by a foster parent, this authorization is valid only for release of immunization records to school administration. Foster parents do not have parental HIPPA rights for foster children in their care.

By:_____ Date:_____
(Patient)

By:_____ Date:_____
(Patient's legal representative)

Representative's authority (e.g. parent, legal guardian):_____
