SOUTHEAST IDAHO
FAMILY PRACTICE & OBSTETRICS

Dr. B Bennett **Dr. Mayo** **Dr. Mclaughlin** **Dr. E Bennett** **Cathy Arvidson** **Jonathan Rozack**

Head of Household

Last Name:_____ First Name:_____

Date of Birth:____/____/_____ Sex:_____ Primary Language:_____

Race: American Indian / Native Hawaiian / White / African American / Other _____

Ethnicity: Hispanic or Latino / Non-Hispanic / Other_____

Address:_____City/State:_____ Zip:_____

SSN:_____/_____/_____ Home Phone:_____Cell Phone:_____

Employer:_____Work Phone:_____

Email:_____

Spouse Information

Last Name:_____ First Name:_____

Date of Birth:____/____/_____ Sex:_____ Primary Language:_____

Race: American Indian / Native Hawaiian / White / African American / Other _____

Ethnicity: Hispanic or Latino / Non-Hispanic / Other_____

SSN:_____/_____/_____ Home Phone:_____Cell Phone:_____

Employer:_____Work Phone:_____

Email:_____

Emergency Contact

Name:_____ Relationship:_____ Phone:_____

Children (18 and younger)

Name	Sex	Date of Birth	Name	Sex	Date of Birth
		___/___/___			___/___/___
		___/___/___			___/___/___
		___/___/___			___/___/___
		___/___/___			___/___/___

⇖ **I authorize my spouse access to my medical information and billing.**

⇖ **(Patients 18 or over) I authorize my parents access to my medical information and billing.**

⇖ **I authorize _____ access to my medical information and billing.**

Insurance

Primary Insurance:_____ ID#:_____ Group#:_____
Policy Holder's Name: _____ DOB: _____/_____/_____ SSN _____/_____/_____
Relationship to patient:_____

Secondary Insurance:_____ ID#_____ Group#:_____
Policy Holder's Name:_____ DOB:_____/_____/_____ SSN:_____/_____/_____
Relationship to patient:_____

ASSIGNMENT OF BENEFITS: I assign my insurance proceeds and/or health benefits to Southeast Idaho Family Practice (SEIFP) and authorize my insurance co. and/ or benefits administrator to pay those assigned proceeds/benefits directly to SEIFP to endorse co issues remittances to be applied to my account.

RELEASE OF INFORMATION: I authorize SEIFP to release any information required to process all claims to another physician or facility that may be necessary in the course of examination and treatment.

PAYMENT DUE : I understand that my **co-payment/co-insurance** is due at the time of service unless prior arrangements have been made. **I also understand that any remaining balance is due and payable within 60 days of the date of service**. I understand that I am financially responsible for all charges whether or not paid by my insurance and/or benefits administrator and that SEIFP will submit billings to my insurance company and/or benefits administrator only as a courtesy to me. I am responsible to know my health benefits, insure that my insurance company and/or benefits administrator pays these benefits to SEIFP, and to negotiate with my insurance company and/or benefits administrator over any disputed claim.

FINANCIAL TERMS: I agree that SEIFP may charge 18% interest on all outstanding balances. If my account is assigned to a collection agency for collection and a suit is filed to recover payment on my account. I agree to pay reasonable attorney's fees. In the event of default, I further agree to pay reasonable costs of suit. If I contest entry of default, I agree that the court may award a reasonable attorney's fee under Idaho law and that this award may exceed the amount of the attorney's fees otherwise awarded in the event of default. I further agree to pay reasonable costs of suit.

CONSENT TO TREATMENT: I give my informed consent for any physicians of SEIFP and medically licensed staff members to perform necessary treatment for me or my minor children even when not accompanied by a parent or legal guardian.

OWNERSHIP DISCLOSURE: Please note that the physicians of Southeast Idaho Family Practice have individual ownership interests in Mountain View Hospital. If you would prefer to receive care or testing at another hospital or facility, please discuss this with your treating physician so he or she may determine if that is possible.

_____ _____

RESPONSIBLE PARTY SIGNATURE DATE