☐ **Dr. Bennett** ☐ **Dr. Hiendlmayr** ☐ **Dr. Kent** ☐ **Dr.Mayo** ☐ **Jonathan Rozack FNP-C** ☐ **Valerie Erickson FNP**

Patient Information:

Last name:________________________ First name:__________________ Preferred name:_____________

DOB:_________________________ Sex assigned at birth ☐Male or ☐Female

SSN # _______/_______/_______

Address:____ City:__________State:________Zip:_____________

Language: _______________________ Please mark if patient is deaf ☐

Sexual Orientation: ☐Choose not to disclose ☐Straight or heterosexual ☐ Lesbian, gay or homosexual ☐Bisexual ☐Do Not Know ☐ Something else, please describe:____

Race: ☐ American Indian ☐Asian ☐African American ☐White ☐Other (Please Specify)________________

Ethnicity: ☐ Hispanic or Latino ☐Non Hispanic ☐ Other (Please specify)________________________

Responsible Party:

Last name:________________________ First name:______________________ DOB:_____________

Relationship: ___________________Email Address:____________________________________

*Providing an email address will give you access to the patient portal. It will only be used to share important health information such as labs,and medication requests.

Home Telephone:_________________ CellNumber:____________Consent to text: ☐ yes ☐no

Emergency Contact:

Name: _________________________ Relationship: ________________________Phone Number:___________________

☐ I authorize ____________________ access to medical and billing information.

<u>Insurance</u>

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:_____________________

How did you hear about our practice?

☐ Referred by another office ☐ Referred by a friend/family member ☐ Your insurance

☐Other, please specify _____________________

Initial Here:

_________ 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.

_________ 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.

_________ 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.

_________ TELEHEALTH AGREEMENT: This establishment provides telemedicine visits via Doximity (a HIPAA complaint platform.) The laws that protect the privacy and confidentiality of health and care information also apply to telemedicine. Information obtained during telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telemedicine visit.

____ _________________________

RESPONSIBLE PARTY SIGNATURE/ RELATIONSHIP **DATE**

*By signing I am taking financial responsibility for all charges whether or not paid by insurance.

SOUTHEAST IDAHO FAMILY PRACTICE

NOTICE OF PRIVACY POLICIES

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this notice, please contact this office.

As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment, and health care operation. These facts can be used or disclosed without your consent in the following, but not limited to, situations:

- In emergency treatment situation, if we try to obtain consent as soon as possible after treatment;
- Where significant barriers to communication with you exist and we determine that the consent is clearly inferred form the situation:
- Where we are required by law to provide treatment and are unable to obtain consents:
- Where the use of disclosure is required by law:
- For certain public health activities, such as reporting births, deaths, injuries, diseases, etc:
- Where we reasonably believe you are a victim of abuse, neglect, or domestic violence, then only to a government agency authorized to receive such reports:
- Health oversight activities:
- Certain legal administrative proceedings:
- Certain law enforcement purposes:
- To coroners, medical examiners, and funeral directors in certain situations (home health, hospice, ect);
- For certain research purposes;
- To avoid a serious threat to health and safety;
- For specialized government functions;
- For Worker's Compensation purposes.

Facts about you that do require consent include, but are not limited to, the following information:

- A release of information contained in financial and or medical records;
- Diseases spread person to person;
- Drug and or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Any other related facts.

You have the right, subject to certain conditions, to:

- Request restrictions on certain uses and disclosures of facts about you by filling out a request. However, we are not required to agree to the requested restrictions;
- Receive confidential communication of protected health data by giving us another address or means of receiving health information.
- Inspect and copy protected health data by filling out our request form;
- Amend protected health data by filling out our form;
- Receive a list of disclosures made of your protected health data by filling out our request form;
- Obtain a paper copy of this notice upon request, if you agreed to receive this notice by e-mail, fax, or website.

This notice goes into affect 03/01/03.
More details can be found at www.state.id.us/phd6

I understand that, under the Health Insurance Portability & Accountability Acct of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed by you of your Notice of Privacy Practices and I have been given the right to review a complete description of the uses of disclosures of my health information as stated in such Notice of Privacy Practices prior to signing the consent I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy or the Notice. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name(s):______________________________

Signature of Patient or Legal Guardian:______________________________ Date:______________

☐ YES ☐ NO **Please indicate if you would like a copy of this HIPAA Form for your records**