SEIFP
SOUTHEAST IDAHO FAMILY PRACTICE

☐ **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:_____
Home Telephone:_____ Cell number:_____ Work Number:_____
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.

Language: _____ Please mark if patient is deaf ☐ Consent to text: ☐ yes ☐no
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)_____
Spouse name: _____Phone Number:_____ DOB: _____

☐I authorize my spouse to access my medical and billing information.
☐I want my spouse to be my emergency contact.

Emergency Contact:

Name: _____ Relationship: _____Phone Number:_____
☐ I authorize _____ access to my medical and billing information.

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:_____

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.

_____ 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.

_____ 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 **DATE**