Post Falls Family Medicine, PA

PRE-HISTORY INFORMATION PAGE 1

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Referred By: _____

1. State in your own words the major medical reason(s) for coming in today:

_____

_____

_____.

2. Please list all medications that you use. Please bring these with you:

_____

_____.

3. Drug Allergies? None: _____ If yes, please list: _____.

4. Family History: please indicate the health or cause of death of members of your family as best as you can:

	Age if Living	Age at Death	Indicate any serious diseases	Cause of death
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				
Other				

Please indicate which of your relatives have/had the following diseases: example: grandmother-mothers side

Disease	**Mothers side**	**Fathers side**
Arthritis		
Cancer		
Diabetes		
Heart Problems		
High Blood Pressure		
Kidney Disease		
Mental/Emotional		
Stroke		
Tuberculosis		
Other		

5. **Menstrual History**

Number of pregnancies	
Number of live births	
Last menstrual period	
Age at menopause	

6. **Please indicate by checking yes or no if you have had significant problems in the below areas. Please comment on special problems and indicate approximate dates:**

Yes	**No**	**Nature of Problem**	**Comment/Approximate Dates**
		Recent weight loss	
		Headaches	
		Trouble with vision	
		Trouble with hearing	

PRE-HISTORY INFORMATION PAGE 2

Yes	No	Nature of problem	Comment/Approximate Dates
		Allergic Reaction to medications? Name:	
		Allergies: Hay Fever? Asthma?	
		Thyroid (Goiter)	
		Diabetes	
		Skin Problems	
		Anemia or Abnormal Bleeding	
		Heart Problems	
		Circulation Problems	
		High Blood Pressure	
		Chest Pain	
		Lung Problems (Pneumonia, TB, etc.…)	
		Shortness of breath, coughing, pleurisy, wheezing	
		Liver Disease, Gallbladder disease, Jaundice	
		Stomach problems: Ulcers, indigestion, change in bowels, constipation, diarrhea	
		Abdominal Pain	
		Kidney disease or stones	
		Urination Problems	
		Female organs	
		Joint Pain or Stiffness	
		Phlebitis	
		Do you smoke? How much?	
		Do you drink alcoholic beverages? How much?	
		Coffee? How much?	
		Depression	
		Nerves, difficulty sleeping	
		Psychiatric	
		Fainting or convulsion	
		Stroke	
		Pain in other areas	
		Other Illness or problems	

7. Please give details of any of the following:

	Approximate Dates	Surgeon	Hospital
Operations:			
Serious Injuries:			

PLEASE BE SURE THAT YOU HAVE FILLED OUT BOTH PAGES OF THIS FORM!

Please feel free to attach any other recorded information, which you feel, will be of importance to the doctor in evaluating your health problems.

Post Falls Family Medicine, PA

Child(ren) Demographic Information

Today's Date: _____ How did you hear about us? _____

Child's full Name: _____ Date of Birth: _____ SS#: _____ M or F
Race *(government census)*:
American Indian or Alaskan Native_____ Asian_____ Black or African American_____ White_____ Native Hawaiian or Other Pacific Islander_____ Declined to Specify _____
Ethnicity:
Hispanic or Latino _____ Not Hispanic or Latino _____ Declined to specify_____
Language Preference: _____

Do the child/children live with both parents? **Y/N** If not, who is the legal guardian? _____
Child's Physical Address: _____City: _____ State: _____ Zip: _____
Child's Mailing Address: _____ City: _____ State: _____ Zip: _____
Best contact phone #: _____ whose phone is this _____ Alt. phone: _____

Mother's Information

Mother's full name: _____ Phone/Cell: _____ SS#: _____ DOB:_____
Address: _____ City: _____ State: _____ Zip: _____

Father's Information

Father's full name: _____ Phone/Cell: _____ SS#: _____ DOB:_____
Address (if different from Mother's): _____ City: _____ State: _____ Zip: _____

Person Responsible for the account
(No absent parent billing)
Please note, just because a parent carries the child under their insurance plan, does not mean they are responsible for the balance due after insurance has processed. Please indicate who will be responsible for the account.

☐ Mother ☐ Father ☐ Other: _____

Additional children: (if any)
Child's full Name: _____ Date of Birth: _____ SS#: _____ M or F
Race *(government census)*:
American Indian or Alaskan Native_____ Asian_____ Black or African American_____ White_____ Native Hawaiian or Other Pacific Islander_____ Declined to Specify _____
Ethnicity:
Hispanic or Latino _____ Not Hispanic or Latino _____ Declined to specify_____
Language Preference: _____

Child's full Name: _____ Date of Birth: _____ SS#: _____ M or F
Race (government census):
American Indian or Alaskan Native_____ Asian_____ Black or African American_____ White_____ Native Hawaiian or Other Pacific Islander_____ Declined to Specify _____
Ethnicity:
Hispanic or Latino _____ Not Hispanic or Latino _____ Declined to specify_____
Language Preference: _____

Child's full Name: _____ Date of Birth: _____ SS#: _____ M or F
Race *(government census)*:
American Indian or Alaskan Native_____ Asian_____ Black or African American_____ White_____ Native Hawaiian or Other Pacific Islander_____ Declined to Specify _____
Ethnicity:
Hispanic or Latino _____ Not Hispanic or Latino _____ Declined to specify_____
Language Preference: _____

Post Falls Family Medicine, PA

Release of Information

I (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patients' medical records to any entity, which is, or may be liable for all or part of the provider charges.

I (we) authorize the release and disclosure or any and all medical records to any other entity including by not limited to referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing for the treatment of patient.

I (we) authorize the release of records necessary as assist in reimbursement of benefits to which I (we) may be entitled. I (we) authorized this office and/or its employees to release via fax machine medical records which are needed in order to provide patient with the most appropriate medical care.

I (we) authorize the release of my x-rays, labs and medical results to be left on my answering machine if I am unavailable. Yes____ No_____

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

By signing below, I have read and understand Post Falls Family Medicine Release of information policy.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Patient signature or parent/guardian if minor Date

Post Falls Family Medicine, PA

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMAION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

About Us

In this notice, we use terms like "we", "us" or "our" to refer to Post Falls Family Medicine, PA and it's physicians. We are a family practice specializing in keeping you and your family in good health.
This notice applies to Post Falls Family Medicine and its physicians.

What is "Protected Health Information" or "PHI"?

"Protected health information", or "PHI" for short, is information that identifies who you are and relates to, your past, present and future physical or mental health or condition, the provision of health care to you, or past, present or future payment for the provision of health care to you. PHI does not include information about you that is publicly available or that is in a summary form that does not identify who you are. If you are an employee of our participating physician's office, PHI does not include your health information in your personal life.

Purpose of this notice

In the course of doing business, we gather and maintain PFI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practices and how we protect the confidentiality of our PHI. We are obligated to maintain the privacy of your PHI implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this notice about our legal obligations to maintain the privacy of your PHI. We must follow our notice that is currently in effect.

How we protect your PHI

We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical, electronic, and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a privacy officer, which has overall responsibility for developing, training, and overseeing the implementation and enforcement of polices and procedures to safeguard your PHI against inappropriate access, use, and disclosure.

Types of use and disclosure of PHI we may make without your authorization

Treatment; Payment; Health Care Operations

Federal and state law allows us to use and disclose our PHI in order to provide health care services to you, as well as to bill and collect payments for the health care services provided to you by our physicians. For example, we may use your PHI to authorize referrals to specialists and to review the quality of care provided by your participating physician. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our physicians.

We may also use or disclose your PHI, for example, to recommend to you treatment alternatives, to inform you about health-related benefits and services that we offer or to contact you to remind you of our appointments. We conduct these activities to provide health care to you and not as marketing.

Federal and state law also allows us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use our PHI in connection with population-based disease management programs. We may use or disclose your PHI to perform certain business functions to our business associates, who must also agree to safeguard your PHI as required by law.
We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law- In some circumstances, we are required by federal or state laws to disclose certain PHI to others, such as public agencies for various reasons.
2. For public health activities- Such as report about communicable diseases, defective medical devices to the FDA or work-related issues.
3. Reports about child and other types of abuse, neglect, or domestic violence.
4. For health oversight activities- Such as reports to governmental agencies that are responsible for licensing physicians or other health care providers.
5. For lawsuits and other legal disputes- In connection with court proceedings or proceedings before administrative agencies or to defend us or our participating physicians in a legal dispute.
6. For law enforcement purposed- Such as responding to a warrant or reporting a crime.
7. Reports to coroners, medical examiners, or funeral directors- To assist them in performance of their legal duties.
8. For tissue or organ donations- To organ procurement or transplant organizations to assist them.
9. For research- To medical researchers with an approval of an institution review board (IRB) or privacy board that oversees studies on human subjects. Researchers are also required to safeguard our PHI.
10. To avert a serious threat to the health or safety of you or other members of the public.
11. For national security and intelligence/military activities- Such as protection of the President or foreign dignitaries
12. In connection with services provided under workers' compensation law.

We may disclose your PHI, without your written authorization, to your family members or other persons if they are involved in your care or payment for that care. We may also notify disaster relief organizations to assist them with their relief efforts. When you are a patient at a hospital or medical facility with which we are affiliated, we may create a directory that includes your name, your location at the facility, your general condition and your religious affiliation. Information in this director may be disclosed to visitors and clergy. However, we must first provide you with an opportunity to agree to such disclosure. If you cannot agree or object because you are incapacitated or otherwise unavailable, we will use our professional judgment.

You, as a parent, can generally control your minor child's PHI. In some cases, however, we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission.

There are some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. However, even such PHI may be used or disclosed without your written authorization if required or permitted by law.

Authorization

All other uses and disclosures of your PHI must be made with your written authorization.

If you need an authorization form, we will send you one for you or your personal representative to complete. When you receive the form, please fill it out and send it to the following address:

Post Falls Family Medicine, PA
1220 E. Polston Ave.
Post Falls, ID 83854

You may revoke or modify your authorization at any time by writing to us at the same address. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

Your rights regarding your PHI

Access to your PHI

You have the right to review and copy your PHI we maintain. If you wish to access your PHI, please write to us. We will respond to your request and tell you when and where you can review your PHI in our possession within our normal business hours. If you would like a copy of the information we have, please write to us at the same address. If we provide you with a copy, we may charge a reasonable administrative fee for copying your PHI to the extent permitted by applicable law. If we deny your request for review or copy of your PHI, we will explain the reason in writing. If we do not have your PHI, but know who does, we will tell you whom to contact.

Right to Amend your PHI

You have the right to request amendments to your PHI. If you wish to have your PHI corrected or updated, please write to us and tell us what you want changed and why. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why. You may also send us an addendum that is no longer than 250 words in length for each item you believe is incorrect. Please clearly indicate that you want the addendum to be included in your PHI. We will attach your addendum to the record(s) of your PHI. Your amended PHI will be available for your review upon request.

Right to Receive an accounting of disclosure of your PHI

You have the right to request an accounting of certain disclosures that we make of your PHI. You can request an accounting by writing to us. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provider to you. We will respond to your request within a reasonable period of time but no later than 60 days after we receive your written request.

Right to receive a copy of this notice

You have the right to request and receive a paper copy of notice.

Right to request restrictions

You have the right to request restrictions on how we used and disclosed your PHI for our treatment, payment, and health care operations. All requests must be made in writing. Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Please note that we are not required to accept your request for restrictions. Your PHI is critical for providing you with quality health care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI and that additional restrictions may be harmful to your care.

Right to confidential communications

You have the right to request that we prove our PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternative means (e.g. sending by a sealed envelope, rather than a post card) or to an alternate address (e.g. calling you at a different telephone number or sending a letter to you at your office address rather than your home address). We will accommodate any reasonable request, unless they are administratively too burdensome or prohibited by law.

Right to complain

We must follow the privacy practices set forth in this notice while in affect. If you have any questions about this notice, wish to exercise your rights, or file a complaint; please direct your inquiries to:

Post Falls Family Medicine, PA
1220 E. Polston Ave.
Post Falls, ID 83854

You may contact your health plan or the Idaho Medical Association with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint against us.

Rights reserved

We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in this notice. We reserve the right to revise our privacy practices consistent with law and make them applicable to your entire PHI we maintain, regardless of when it was received or created. If we make material or important changes to our privacy practices, we will promptly revise our notice. Unless, law requires the changes, we will not implement material changes to our privacy practices before we revise our notice. You may request updates to this notice at any time.

Effective date of notice is 02/01/2003

I, the undersigned patient, and/or responsible party have read and received a copy of Post Falls Family Medicine, PA's Privacy Statement.

PRINT NAME: _____ **DATE OF BIRTH**: _____

SIGNATURE: _____ **DATE**:_____

Post Falls Family Medicine, PA

Patient Financial Policy

Thank you for choosing the physicians of ***Post Falls Family Medicine*** as your health care providers. We are committed to providing you with quality care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please do not hesitate to contact our billing department at 208-773-4097. Please take time to carefully review the following information and return this form to the front desk with your signature and today's date.

We require that all patients complete our Patient Financial Policy prior to seeing the physician. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

You are ultimately responsible for the timely payment of your account.

INSURANCE

- It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit and will make a copy for our records.
- If current information is not obtained at the time of service, it will become the patient's responsibility to pay the entire balance until current information is provided to our office.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file all your claims for you. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. Post Falls Family Medicine is not responsible for ensuring we are in-network with your specific insurance policy. Please call the number on the back of your insurance card to have them check network status using tax id 82-0496462.

CO-PAYS

Co-payments are due at the time you check in at the front desk **PRIOR** to your being seen by our physicians.

DEDUCTIBLES, CO-INSURANCE and ESTIMATES:

- Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of service.
- For surgical and in-office procedures, an estimation of patient responsibility will be provided to you and is to be paid **in full** PRIOR to services being rendered.
- Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

UN-PAID/OUTSTANDING BALANCES

- We ask that full payment to be made at the time of service unless prior arrangements have been made through the billing office.
- If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due.
- You may call our billing office at 208-773-4097 to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity.

Forms of payment accepted: Cash, Checks, Visa, MasterCard, American Express and Discover.

RETURNED CHECKS

The charge for a returned check is $25.00 plus any additional bank charges accrued payable by cash, check, money order or credit card charge.
This will be applied to your account in addition to the insufficient funds amount.

MISSED APPOINTMENTS

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a **24-hour notice**.
Failure to provide notice after the 2nd missed appointment will result in a **$35.00** missed appointment charge.
This charge is the responsibility of the patient and is not covered by any insurance carrier.

CREDIT BALANCES

From time to time, you may accrue a credit balance on your account. If your account reflects a credit balance of **$20.00 or less**, Post Falls Family Medicine's policy is to carry the balance on the account until your next appointment.
If your account reflects a credit balance of **more than $20.00**, Post Falls Family Medicine will maintain your credit until our Accounts Receivable staff processes your credit or a request is made by you, the patient, to receive a refund. All refunds are reviewed and processed every **45 days**, if you make a request please allow ample time for review of your entire account and processing through our billing department. You can contact our billing department at 208-773-4097 regarding any credits on your account.

Like all businesses it is our intention to thoroughly explain our financial policies and set forth our expectations. Your assistance and cooperation is appreciated.

We are pleased to have the opportunity to meet your health care needs and encourage you to contact our billing department (208) 773-4097 with any questions or concerns.

I have read Post Falls Family Medicine Patient Financial Policy and acknowledge my responsibilities by affixing my signature below.

_____
Patient Name (please print)

_____
Patient Date of Birth

_____
Patient/Responsible Party Signature

_____
Date

Why did I get a bill for a preventive care visit?

Learn the difference between a preventive visit and an office visit, including when you'll have to pay for the visit.

A preventive care visit with your doctor focuses on your overall health and how to stay healthy. But a preventive visit may turn into an office visit that costs you money. Learn why.

When does a preventive visit become an office visit?

A preventive care visit is different from an office visit:

- **The purpose of a preventive visit** is to review your overall health, identify risks and find out how to stay healthy. Your plan covers 100% of a preventive visit when you see a doctor in your plan network.
- **The purpose of an office visit** is to discuss or get treated for a specific health concern or condition. You may have to pay for the visit as part of your deductible, copay and/or coinsurance.

If you schedule a preventive care visit and ask your doctor about a specific health concern or condition, your clinic may code and bill the appointment as an office visit.

If you want to know about costs, ask your doctor for an estimate of fees before you visit. You can also call the number on the back of your member ID card. The table below shows what services are covered during a preventive visit.

What can I discuss at a preventive visit without getting charged?

During your preventive care visit, your doctor will look at your health risks and talk with you about:

- Your current health
- Your family health history
- Past illnesses and surgeries
- Risks you may have for specific conditions
- How to maintain a healthy lifestyle

What is the difference between a preventive care visit and an office visit?

A preventive care visit *Your plan covers 100% of these services*	**An office visit** *You must pay for these services*
• Check your weight, height, temperature, blood pressure and pulse • Listen to your heart and lungs • Check your ears, eyes, throat, skin, and abdomen • Various immunizations • Various cancer screenings, such as for breast, colorectal, cervical, and prostate cancer • Certain blood tests to check such things as cholesterol or blood sugar	• Discussing or getting treatment for a specific health concern, condition, or injury • Lab work, X-rays or additional tests related to a specific health concern, condition, or injury

Proper preventive care is important to help you live a longer, healthier life. A preventive checkup can help prevent disease before it starts and detect problems early before they cause serious illness.

I have read the above information and understand that by signing; I will be responsible for any charges my insurance does not cover that fall outside of the Preventive Care Visit.

_____ _____

Patient Name (Please Print) Signature

_____ _____

Date of Birth Date