innovative FAMILY MEDICINE

PATIENT INFORMATION

Patient: ____
Mr./Ms./Mrs. *(Last)* *(First)* *(MI)* *(Suffix)*

Date of Birth ________________________ *Gender:* *M* *F* _____ *SSN:* ________________________
*Previous Name:*________________________ *Preferred Name:*________________________

CONTACT INFORMATION

*Address:*____
(Street) *(City)* *(State)* *(ZIP)*

*Phone: Home:*_____________ *Work:*_____________ *Cell:*_______________ *Other:* _____________
Email: __________________________________
How Would You Like Us to Contact You: *Home* *Work* *Cell* *Other* *Email*
Pharmacy Name and Store Location:
____

DEMOGRAPHIC INFORMATION

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widow

Preferred Language
- ☐ Unspecified
- ☐ English
- ☐ Spanish
- ☐ Other: __________

Race
- ☐ Unspecified
- ☐ Black or African American
- ☐ White
- ☐ Native American or other Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Other
- ☐ Asian

Ethnicity
- ☐ Unspecified
- ☐ Hispanic or Latino
- ☐ Not Hispanic/Latino
- ☐ Unknown

EMERGENCY CONTACT INFORMATION

*Emergency Contact:*______________________________________ *Relation:* ______________________

Home: ______________________ *Mobile:* ______________________ *Other:*______________________

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I give permission for Innovative Family Medicine of Idaho, PLLC (IFMI) to provide any information about my medical condition, medical needs, medications, or the status of my account to the following individual(s). I understand that I must give express permission for IFMI to discuss any information related to mental health conditions and/or sexually transmitted disease unless allowed by law.

Name: ____________________________ *Phone:*________________________ *Relationship:* ________________

Name: ____________________________ *Phone:*________________________ *Relationship:* ________________

Name: ____________________________ *Phone:*________________________ *Relationship:* ________________

☐ *Patient declines releasing any information to a designated person*

How did you hear about us? ____

Please continue on the next page.

BILLING INFORMATION

Guarantor – Person/Entity Responsible for Payment			
Name:	*Relationship to Patient:*		*DOB:*
Address:	*City:*	*State:*	*Zip:*
Home Phone:	*Work Phone: x*	*Cell Phone:*	
Employer:	*Occupation:*		

***Primary** Insurance Coverage*		
Ins Co. Name:	*Subscriber Name:*	*Subscriber DOB:*
Pt. Relation to Subscriber:	*Policy ID#:*	*Group #:*
Network (circle): SLHP IPN BrightPath Aetna FirstHealth CCN	*Effective Date:*	*Group Name:*
Subscriber Address/Phone:	*Insurance Address:*	
	Insurance Phone:	

***Secondary** Insurance Coverage*		
Ins Co. Name:	*Subscriber Name:*	*Subscriber DOB:*
Pt. Relation to Subscriber:	*Policy ID#:*	*Group #:*
Network (circle): SLHP IPN BrightPath Aetna FirstHealth CCN	*Effective Date:*	*Group Name:*
Subscriber Address/Phone:	*Insurance Address:*	
	Insurance Phone:	

ACKNOWLEDGEMENTS

Release of Information: *I authorize IFMI to furnish medical and other information necessary to process insurance claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care.*

Financial Responsibility: I understand and agree that I am responsible for payment on all charges including those not paid by my insurance at the time of service. If I fail to make payment in full for services that are rendered to me within 90 days of the date of service, my outstanding balance will be sent to a collection's agency. I understand that if my account is transferred to a collection's agency, any discounts I may have received (excluding insurance contract) can be reversed.

Receipt of Financial Policy: *I have been offered and/or provided with a copy of IFMI's Financial Policy that explains IFMI's policies and procedures for payments, collections, appointment no-shows, late charges, etc. I acknowledge the receipt of IFMI's Financial Policy.*

Receipt of Privacy Practices: *I have been offered and/or provided with a copy of the Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and state regulations. I acknowledge the receipt of IFMI's Notice of Privacy Practices.*

Statements/Messaging: *I understand and agree that, by default, IFMI utilizes electronic means to communicate with patients, including but not limited to financial statements, requests for payment, appointment reminders, etc. I must let IFMI know if I would like to opt out of this type of communication.*

Appointments: I understand that if I do not notify IFMI of a cancellation of my appointment at least 24 hours prior to the scheduled appointment, I may be assessed a $25 fee and/or dismissed from the practice for multiple occurrences.

Treatment Authorization: *I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at IFMI. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of the patient's care or treatment. I authorize a copy of this document to be used in lieu of the original.*

Liability: *I understand that IFMI is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by IFMI may be involved in my care and treatment, including but not limited to other practitioners, laboratories, diagnostic test facilities, contractors, vendors, product technicians, etc. I understand that IFMI is not liable for the acts or omissions of non-employees or employees acting outside the course and scope of their duties.*

____   ____________________

Signature of Patient or Legal Guardian   ***Date Signed***

PATIENT NAME: ______________________________________ DOB: ________________ PATIENT ID: ______________

Consent to Treat Form

1. I ____________________ (patient name) give permission for **Innovative Family Medicine of Idaho** to give me medical treatment.

2. I allow **Innovative Family Medicine of Idaho** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Innovative Family Medicine of Idaho** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____________________________________ ________________
Patient's Signature Date

_____________________________________ ________________
Parent or Guardian Signature Date
(for children under 18)

_____________________________________ ________________
Print name

CONSENT AND CONDITIONS OF TREATMENT

Patient Name: ____ ("Patient")
Birth Date: ___/___/___

CONSENT FOR TREATMENT. On my own behalf and on behalf of the Minor Patient, I voluntarily consent to and authorize Innovative Family Medicine of Idaho physicians, practitioners, and staff to render health care services to the Minor Patient, including but not limited to diagnostic, laboratory, and radiological tests and procedures; examination, counseling, prescribing and rendering treatment; and such other health care services as defined Idaho Code 39-45 as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. This consent and authorization shall constitute a "blanket consent" within the meaning of Idaho Code 32-1015(4)(a) and no further consent is required from me to authorize such health care services. If I require additional information concerning the health care services to provide effective consent, I will contact Innovative Family Medicine of Idaho or the attending physician, practitioner or staff personnel to discuss such services. I understand and acknowledge that Innovative Family Medicine of Idaho and/or its physicians, practitioners and staff may render health care services in reliance on this consent and authorization.

ADVANCE DIRECTIVES. Please indicate whether the Patient has executed an advance directive, e.g.:
[ ] Living Will [ ] Durable Power of Attorney [ ] POST [ ] Other (describe): ________________________
I understand that it is Innovative Family Medicine of Idaho's policy not to comply with advance directives that would prohibit life sustaining treatment. I consent to such treatment on behalf of the Patient, and agree that any contrary directions in the Patient's advance directives shall be suspended while the patient receives care at Innovative Family Medicine of Idaho.

PATIENT CONTACT AND COMMUNICATION. I request that Innovative Family Medicine of Idaho communicate with me at the following addresses or numbers. I understand that communications via text or e-mail may not be secure .
[ ] Phone: (_____) ______-_______________
[ ] Text: (_____) ______-_______________
[ ] E-mail: ______________________________

To the extent consent is required by the Telephone Consumer Protection Act ("TCPA ") or other applicable law, I authorize Innovative Family Medicine of Idaho and its designees to deliver messages containing account, marketing, or other non-health care messages to the phone number(s) identified above via an automatic telephone dialing system or an artificial or prerecorded voice. I understand that I am not required to agree to receive such automated calls, and my agreement is not a condition to receiving items or services from Innovative Family Medicine of Idaho. Innovative Family Medicine of Idaho does not waive and expressly reserves the right to contact Patient by any means for any purpose as otherwise permitted by law.

[Portal – Healow App]

CONDITIONS FOR TREATMENT AT PRACTICE. In consideration for the care and treatment that Patient will receive or has received at Innovative Family Medicine of Idaho, I agree to the following:

1. **Patient Responsibilities.** I agree to comply with the Patient Responsibilities set forth in Innovative Family Medine of Idaho's separate Notice of Policies, Patient Rights, and Patient Responsibilities.

2. **Payment.** I agree that I am responsible for any co-payments, deductibles or other charges for services to Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and Innovative Family Medicine of Idaho. I agree to make such payments according to Innovative Family Medicine of Idaho's regular terms of payment. Where appropriate, I agree to submit and cooperate with Innovative Family Medicine of Idaho in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to Innovative Family Medicine of Idaho's policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.

3. **Assignment and Authorization.** I hereby assign and authorize direct payment to Innovative Family Medicine of Idaho of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with

Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Innovative Family Medicine of Idaho Practice or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Innovative Family Medicine of Idaho's right to use or disclose protected health information as otherwise allowed by applicable law or Innovative Family Medicine of Idaho's Notice of Privacy Practices.

4. Billing Practices. I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. Innovative Family Medicine of Idaho may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that Innovative Family Medicine of Idaho will require payment of all accounts at the time the services are rendered unless Innovative Family Medicine of Idaho has expressly agreed to contrary arrangements. Where insurance is available, Innovative Family Medicine of Idaho will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

PERSONAL PROPERTY. I understand and agree that Innovative Family Medicine of Idaho does not assume any responsibility for my personal property and shall not be liable for any loss or damage to such personal property.

NO GUARANTEE. I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at Innovative Family Medicine of Idaho.

PERSONS FOR WHOM PRACTICE IS NOT LIABLE. I understand that Innovative Family Medicine of Idaho is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by Innovative Family Medicine of Idaho may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that Innovative Family Medicine of Idaho is not liable for the acts or omissions of non-employees or Innovative Family Medicine of Idaho employees acting outside the course and scope of their duties.

INJURY CAUSED BY THIRD PARTY. Please indicate the following:
[ ] My condition was <u>not</u> caused by the wrongful act or omission of another person.
[ ] My condition <u>was</u> caused by the wrongful actions of the following person[s]:

Name: ____________________________________
Address: ____________________________________
____

NOTICE OF PRIVACY PRACTICES. I have received a copy of Innovative Family Medicine of Idaho's Notice of Privacy Practices on this or a prior occasion. [Please Initial]: __________

NOTICE OF PATIENT RIGHTS AND PATIENT RESPONSIBILITIES. I have received a copy of Innovative Family Medicine of Idaho's Notice of Policies, Patient Rights, and Patient Responsibilities on this or a prior occasion. [Please initial]: __________

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

____ ____________________
(Print Name) (Date)

____
(Signature)

____
Relationship to Patient/Authority

PATIENT NAME: ______________________________________ DOB: ________________ PATIENT ID: ______________

FINANCIAL POLICY

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. **INSURANCE** We are participating providers with several insurance plans. We will file all these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage.
   You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a credit card to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.

4. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

5. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours in advance, more than two times, we will assess you a $25 cancellation fee. You will be allowed one no-show appointment before we will assess you a $25 missed appointment fee.

6. **LATE APPOINTMENT:** If you are more than 10 minutes late to your appointment, you will either be asked to wait for an open appointment slot or reschedule for a different day.

7. **RESPONSIBILITY FOR PAYMENT**: I understand that I, personally, am financially responsible to Innovative Family Medicine of Idaho for charges not covered by the assignment of insurance benefits.

9. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign, transfer, and set over directly to Innovative Family Medicine of Idaho sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Innovative Family Medicine of Idaho to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Innovative Family Medicine of Idaho. I authorize Innovative Family Medicine of Idaho to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

10. **SELF PAY PATIENTS OR OUT OF NETWORK PATIENTS:** A 20% prompt pay discount is applied to all full pay payments received within the first payment cycle if patient is self-pay or if we are not in network with your insurance company.

11. **RELEASE OF INFORMATION**: I hereby authorize the and direct Innovative Family Medicine of Idaho to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

12. **COLLECTION FEES**: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

13. **DIVORCED PARENTS of PATIENTS:** By signing below, the parents chose an adult whom is financially responsible for payment of services. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

____ _______________________

Signature of Patient or Legal Guardian ***Date Signed***