Mountain States Medical Group Patient Registration

Date:_____________

Patient

Last Name______________________ First Name_______________________ Intial___
Address____
Billing Address____
City________________________ State____________________ Zip________________
Phone-Home__________________ Work__________________ Cell________________
Social Security Number_________________ DOB_____________ Marital Status______
Employer____

Health Insurance

Primary Insurance__________________________ Effective Date_________________
Group Number____________________________ ID Number_____________________
Policy Holder Name________________________ DOB__________________________
Employer________________________________ Relationship to Patient_____________
Secondary Insurance _______________________ Effective Date________________
Group Number____________________________ ID Number______________________
Policy Holder Name________________________ DOB__________________________
Employer________________________________ Relationship to Patient_____________

Responsible Party

Last Name______________________ First Name_______________________ Intial___
Address____
Billing Address____
City________________________ State____________________ Zip________________
Phone-Home__________________ Work__________________ Cell________________
Social Security Number_________________ DOB_____________ Marital Status______
Employer________________________________ Relationship to Patient_____________

In Case of Emergency

Last Name_____________________ First Name______________ Phone # ___________
Address____________________ City____________ State________ Zip _____________
Relationship to Patient____

We require that patients bring their insurance cards to all appointments. We will take a copy for our records. We are happy to bill your primary and secondary insurance companies, taking this burden off of you. All accounts are due and payable at the time of service unless other arrangements are made prior to the services being rendered. I hereby authorize Mountain States Medical to release all necessary information from my (or this minor's) medical record to my insurance company. In addition, I authorize payment be made directly to Mountain States Medical for any and all medical/surgical services rendered. I understand that if my insurance company should refuse to pay for any services (in whole or in part) within 60 days, payment of this account will be my responsibility, if account isn't satisfied you will be sent to collections. New patients will be asked to pay for initial visit in full, prior to being seen.

Patient/Responsible Party Signature_____________________________ Date__________

How did you hear about our Practice?____

MOUNTAIN STATES MEDICAL
FINANCIAL POLICY

We appreciate the opportunity to provide your healthcare services. The following is a statement of our financial policy. Please feel free to ask any questions before you sign.

PAYMENT POLICY-All deductibles, co-payments, and patient responsibility payments are due and payable at the time of service. New patients are required to pay in full at the time of the first visit, prior to being seen. If we are able to verify that insurance should pay on that visit, we may allow you to pay your portion only. Given our extended hours, we may not be able to contact your insurance company at the time of your appointment.

We accept CASH, IMPRINTED CHECKS, VISA, MASTERCARD, DISCOVER, and BANK DEBIT CARDS. Returned checks are subject to a $25 service charge. If a check is returned, you will have 30 days from the date of our notification to pay the balance and finance charges. If this is not cleared after the 30 days, you will be required to use another method of payment for 1 year. After 2 returned checks, we will require cash/valid credit card payment for 1 year.

INSURANCE-We participate with and are contracted with many insurance companies. It is recommended that you contact your insurance company to see if you have a policy that limits your choice of providers prior to an appointment. We are happy to bill your insurance and assist in any problems that arise. In order to do this accurately, we must have updated card information and a Social Security Number. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in 90 days from the date of service, the balance is your responsibility. Please be aware that some or all of the services provided may not be a covered benefit. Refer to your insurance contract if you have any questions.

Our practice is committed to providing the best treatment for our patients and we base our prices on what is usual and customary for our specialty and location. You are ultimately responsible for any charges incurred; regardless of what your insurance company determines is "Usual and Customary."

MINOR PATIENTS-Non-emergency treatment may be denied without a parent/guardian present or without prior consent. A parent/guardian who schedules an appointment for an unaccompanied minor is considered to be authorizing care for that visit. Emergency treatment will not be withheld, however. We will make every effort to contact a responsible party. The responsible adult accompanying the minor will be responsible for payment at the time of service. Mountain States Medical cannot be held responsible to try to collect from multiple sources (i.e. divorced parents). We will bill the responsible party at the address listed.

INTEREST-We reserve the right to charge interest in the amount of 1.5% per month as allowed by state law.

NO SHOW-NO CANCELLATION POLICY-It is required that a 24 hour notice be given to cancel any scheduled appointment. If a 24 hour notice is not given, Mountain States Medical reserves the right to charge the patient or responsible party a $50 fee per occurrence. Upon third violation of the no show-no cancellation policy dismissal from the practice may occur.

I have read and understand this financial policy. I will adhere to the above guidelines and will have any questions answered before signing.

PRINT NAME OF PATIENT/RESPONSIBLE PARTY___________________________________

SIGNATURE OF PATIENT/RESPONSIBLE PARTY_____________________________________

PATIENT NAME IF DIFFERENT__________________________**DATE**______________________

SIGNATURE ON FILE

COMMERCIAL INSURANCE

I authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the physician or Mountain States Medical. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is valid as the original.

____ ____________________
Signature Date

____ ____________________
Insurance Company ID / Policy #

MEDICARE SIGNATURE ON FILE

Medicare has instructed providers to obtain the following signatures. This signature on file is a lifetime beneficiary authorization and will be on file in the patient record.

I request the payment of authorized **MEDICARE** benefits be made either to me or on my behalf for any services furnished me, by or in Mountain States Medical, including physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administrator and its agents any information needed to determine those benefits or benefits for related services.

____ ____________________
Signature of Beneficiary Date

____
Medicare #

I request that payment of authorized **MEDIGAP** (supplemental) insurance benefits be made either to me or on my behalf to Mountain States Medical for any services furnished to me by that physician / supplier. I authorize any holder of medical information about me to release to the **MEDIGAP** (supplemental) insurance company any information needed to determine those benefits as the benefits payable for related services.

____ ____________________
Signature of Beneficiary Date

____ ____________________
Insurance Company ID / Policy #

NAME______________________________ **HEALTH HISTORY** MOUNTAIN STATES MEDICAL

DOB______________________________ DATE______________________

SMOKING ☐ CIGS ☐ PIPE ☐ CIGAR ☐ CHEWING TOBACCO

NUMBER OF YEARS__________ PACKS PER DAY___________

ALCOHOL USE NO_____ YES_______

HOW MUCH ______________ HOW OFTEN__________________

EXERCISE

WHAT KIND____________________ HOW OFTEN______________________

ALLEGIES OR REACTION TO MEDICATION

____

____

____

MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE VITAMINS, MINERALS & OVER THE COUNTER)

1.____ 2.____________________________________

3. ____ 4. ____________________________________

5.____ 6. ____________________________________

LONGSTANDING MEDICAL PROBLEMS

1. _________________________________ 2. __________________________________

3. _________________________________ 4. __________________________________

SURGERY (KIND OF SURGERY & YEAR OF SURGERY)

1. _________________________________ 2. __________________________________

2. _________________________________ 4. __________________________________

5. _________________________________ 6. __________________________________

Family History on Other Side →

MOUNTAIN STATES MEDICAL
FAMILY HISTORY

FAMILY MEMBER NAME		LIVING		DECEASED	
		AGE	HEALTH	AGE	CAUSE
FATHER					
MOTHER					
SIBLINGS					
SPOUSE					
CHILDREN					

HAVE YOU OR ANY RELATIVE HAD:

	YES	NO	WHOM		YES	NO	WHOM
DIABETES				ARTHRITIS			
GLAUCOMA				GOUT			
THYROID PROBLEMS				ALLERGIES/ASTHMA			
HIGH BLOOD PRESSURE				HEART TROUBLE			
STROKE				CANCER OR TUMOR			
LUNG DISORDER				ANEMIA			
BLEEDING DISORDER				ULCERS			
KIDNEY/BLADDER TROUBLE				EPILEPSY/CONVULSIONS			
BIRTH DEFECTS				OTHER			

MOUNTAIN STATES MEDICAL

Family Practice - Sports Medicine - Urgent Care

PROTECTED HEALTH INFORMATION RELEASE

________ You have my permission to speak with my spouse about my medical care.

________ You have my permission to leave information on my answering machine regarding my medical care and test results.

________ You have my permission to talk with my children or other family members involved with my medical care.

Name______________________ Relationship________________ Number___________

Name______________________ Relationship________________ Number___________

Name______________________ Relationship________________ Number___________

Name______________________ Relationship________________ Number___________

Other, please describe____

____

____ __________________

Patient signature Date

HIPAA NOTICE OF PRIVACY PRACTICES

MOUNTAIN STATES MEDICAL
4809 Fairview Ave.
Boise, ID 83706
(208) 378-2840

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 Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office, i.e. POMS, on-call physicians, that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to se you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures, such as Research or Outside Marketing, Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (208) 378-2840

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ____ Signature: ____

Date: _______________________________