PATIENT INFORMATION

Patient: ____
(Last) (First) (MI)

Date of Birth ____________ Gender: M F SSN: ____________
(xx/xx/xxxx)

DEMOGRAPHIC INFORMATION

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

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

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

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

CONTACT INFORMATION

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

Home: ____________ Mobile: ____________ Other: ____________

Email: ____________ Preferred Contact: Email Phone Letter

Emergency Contact and/or Guarantor: ____________ Relation: ____________

Primary: ____________ Work: ____________ Other: ____________

Employer: ISU (Student) ISU (Employee) West Ada (Employee/Family) CWI (Student)

Employer, if not listed above: ____________

Select: Self-Pay Medicare/Medicaid Commercial Insurance Employment Related

BILLING INFORMATION

Primary Insurance: ____________ Policy Number: ____________

Secondary Insurance: ____________ Policy Number: ____________

PLEASE READ AND INITIAL EACH STATEMENT

Assignment of Benefits: I hereby assign all applicable insurance benefits and direct that payment be made directly to Unity Health Center, PLLC for all services provided during my visit. ________

Release of Information: I authorize Unity Health Center, PLLC 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 in a reasonable time. I understand that visits without payments or payment arrangements within 90 days of date of service will be sent to collections. Interest will be applied to those accounts. _______

Treatment Authorization: *I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at Unity Health Center, PLLC. I authorize a copy of this document to be used in lieu of the original.*

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

Medical History Questionnaire – Please Update at Each Visit

Patient: ______________________ *Date of Birth:* ______________

Preferred Pharmacy: ______________________ *Location:* ______________

Do you smoke? NO YES Packs per day: ________ *Do you drink alcohol? NO YES How often:* ________

Current Medications (please list medication and dosages, if you have a list please note "see list")

For current patients, have there been any medication changes since your last visit? ☐ *Yes* ☐ *No (skip to consent section)*

Allergies (Medications, Environmental, Food, etc)

For current patients, have you encountered any new allergies since your last visit? ☐ *Yes* ☐ *No (skip to consent section)*

Medical and Surgical History (circle all that apply and/or fill in the blanks as appropriate)

For current patients, have you been treated for any conditions since your last visit? ☐ *Yes* ☐ *No (skip to consent section)*

MEDICAL

Anxiety	Bipolar	Diabetes	Hyperthyroidism	________
Arthritis	Cancer	Heart Disease	Hypothyroidism	________
Asthma	Heart Problems	High Blood Pressure	Seizures	________
Atrial Fibrillation	Depression	High Cholesterol	Stroke (TIA/ "Mini")	________

SURGICAL

Appendix	Hip Replacement	________	________	________
Gallbladder	Hysterectomy	________	________	________
Heart Bypass	Knee Replacement	________	________	________
Hernia Repair	Tonsils Removed	________	________	________

Family Medical History (Circle all that apply and/or fill in the blanks as appropriate)

For current patients, have you been treated for any conditions since your last visit? ☐ *Yes* ☐ *No (skip to consent section)*

Mother: *Living Unknown Deceased: (Age/Cause):* ______________________

Father: *Living Unknown Deceased: (Age/Cause):* ______________________

MATERNAL

Cancer: (Type): ________			Depression	Diabetes
Heart Attack(s)	High Blood Pressure	High Cholesterol	Open Heart Surgery	Psychiatric Disorders
Stroke(s)	Thyroid Disease	________	________	________

PATERNAL

Cancer: (Type): ________			Depression	Diabetes
Heart Attack(s)	High Blood Pressure	High Cholesterol	Open Heart Surgery	Psychiatric Disorders
Stroke(s)	Thyroid Disease	________	________	________

CONSENT AND CONDITIONS OF TREATMENT

CONSENT FOR TREATMENT. I voluntarily consent to care and treatment by Unity Health Center, PLLC and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. If Unity Health Center, PLLC personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of Patient for any blood-borne disease for the protection of Unity Health Center, PLLC personnel.

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

- Your health insurance policy is a contract between you and your insurance company. In many instances, the provider is not involved. It is your responsibility to know the specifics of your insurance coverage and benefits.
- We have made prior arrangements with some health care plans to accept benefit assignment. Please call your insurance company prior to your appointment to determine if we are participants in your specific plan. We will submit claims to those plans for which we have a contractual agreement and will require you to pay your authorized co-payment and/or co-insurance and deductible at the time of service. We may collect payment of co-payments and deductibles upon checking in. We accept Checks, VISA, MasterCard, American Express or Cash. It is your responsibility to be prepared to make your co-payment at the time of service. If you are not able to make your co-payment, you may be asked to reschedule your appointment to a time when you are able to do so.
- If you have a health care plan that we do not have a contracting agreement with, we will submit the claim for you on an unassigned basis. In this instance, our charges for your care and treatment for your initial visit may be due at the time of service. As non-contracted providers your insurance company may calculate their reimbursement rates in a manner that may not fully cover your charges. It is important that you understand your health insurance policy and the coverage it provides as you will be financially responsible for any balance on your account, including any non-covered charges.
- Please bring a current copy of your insurance card, photo ID and current referral if required by your insurance to all of your appointments. If proof of insurance is not provided, your account will be set up as "self-pay" and payment will be expected in full at time of service.
- Please advise us of any change in address, phone number, or insurance that may occur.
- Lab/Test results – Depending on the test, and the results received your provider may call you to discuss them or you may be requested to make a follow up appointment. You will be required to be seen at least annually in order to maintain any and all prescriptions.

For the following items, please indicate that you understand by ***initialing each line and signing and dating the box below:***

______ Although your provider may have an ownership interest in laboratory services offered at this facility you have the right to have your lab work drawn at another facility if you so desire. Please let us know if you wish to have laboratory orders sent elsewhere.

______ Not all health plans are the same nor do they all cover the same services and supplies. In the event that your health plan determines a service to be a **"non-covered service"**, you will be responsible for the complete charge for that particular service. Payment is due upon receipt of a statement from our billing office. If you need to make arrangements for a payment plan, please contact our business office at 208.895.6729.

______ Effective May 1, 2016 accounts with patient balances older than 90 days may be subject to a monthly interest charge of 1.5% (18% annually).

______ There will be a $35.00 charge for insufficient fund checks issued for returned items and if your account is turned over to an outside collection agency there will be a $35.00 agency fee charged.

______ **We require at least 48 business hours to review and respond to all prescription requests. You will be required to be seen by provider at least annually in order to maintain any and all prescriptions.**

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 Unity Health Center.

PERSONS FOR WHOM PRACTICE IS NOT LIABLE. I understand that Unity Health Center, PLLC 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 Unity Health Center, PLLC 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 Unity Health Center, PLLC is not liable for the acts or omissions of non-employees or Unity Health Center employees acting outside the course and scope of their duties.

NOTICE OF PRIVACY PRACTICES. I have received a copy of Unity Health Center's Notice of Privacy Practices 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**
______________________________	______________
Guardian/Patient Signature	**Patient Date of Birth**

IMPORTANT NOTICE REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Effective April 14, 2003 and updated September 23, 2013, revised federal regulations restrict the use and disclosure of your private health information (PHI) by our practice and other organizations. It has been, and continues to be, the policy of our practice to protect the privacy of our patient's health information and to comply with guidelines regarding the use and disclosure of patient health information to the best of our ability. The following summarizes the law and under what circumstances your private health information may be disclosed. Please note this is only a summary and a more detailed copy of the law may be obtained for your records.

Permitted Disclosures

Our practice is permitted to use and disclose your PHI for treatment, payment, and health care operation purposes. These uses include, but are not limited to, sharing your PHI with other health care providers for confirmation of a diagnosis and coordination of care, using your PHI to accurately bill services we provide to you, providing your PHI to your insurance company for reimbursement, to remind you of appointments, and as part of our quality improvement program.

We are also permitted to disclose your PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. We may also disclose your PHI to family members, close relatives, and close personal friends when the information we disclose is relevant to the individual's involvement with your care or is required to assist in your health care (e.g. pick-up prescriptions or other documents, note follow-up care instructions, etc.). We will disclose your PHI when we refer you to other physicians or providers of health care. Finally, we reserve the right to change a privacy practice described in this notice as may be permitted or required by law and to make such change effective for all protected health information.

Restricted Disclosures

You have the right to request restrictions on certain uses and disclosures of your PHI and to request portions of your PHI be amended. However, our practice is not obligated to agree to requested restrictions or amend your PHI in the manner you request. You also have the right to inspect and receive a copy of your PHI, but must pay a reasonable charge for the labor and costs associated with copying your PHI. Finally, you have a right to receive an accounting disclosures of your health information.

Authorization for Other Uses

Our practice will make uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing that you wish to revoke your authorization.

Concerns

If you believe your privacy rights have been violated you may make a complaint by contacting the office manager, Cresta Swainston, at 208.895.6729.

Acknowledgement

I acknowledge that I have received this summary and was offered a copy of the Notice of Privacy Practices regarding the use and disclosures of my private health information. A copy of our complete policy is available at our office.

Signature *Date*

PROTECTED HEALTH INFORMATION RELEASE

[ ] Only release information to me personally.

[ ] You **DO NOT** have my permission to leave detailed information on my answering machine regarding my medical care and test results.

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

Name: ______________________________ Phone: ________________

[ ] You have my permission to talk with my children and/or other family members involved with my medical care.

Name: ______________________________ Phone: ________________

Relationship: ________________

Name: ______________________________ Phone: ________________

Relationship: ________________

Name: ______________________________ Phone: ________________

Relationship: ________________

[ ] Other, Please Describe: ____

____

Emergency Contact:

Name (Last, First): ______________________________

Relationship to Patient: ____________________ Phone: ________________

Patient Contact: Preferred Message/Contact Phone

[ ] Phone (Primary): ____________________

[ ] Phone (Work): ____________________

[ ] Phone (Other): ____________________

______________________________________ ____________________

Patient/Guardian Signature Date