# Idaho Falls Pediatrics

3067 Eagle Drive, Ammon, ID 83406
1645 Pancheri Dr., Idaho Falls, ID 83402

Ron Porter MD • Scott Smith DO • J. Ty Webb DO • Joseph Moore MD • Mitchael Steorts MD • Travis Christensen PA-C • Jackie Romrell FNP-C
(208) 522-4600 • (208) 552-7521

## New Patient Form

| | |
|---|---|
| **Please fill out all of the fields. All answers will be kept confidential. If you have any questions, please ask us, and we'll be happy to assist you.** | Who referred you to us: |

## Patient Information (Page 1 of 2)

| | | | |
|---|---|---|---|
| Choose one: ◯ Father ◯ Guardian | First Name: | Middle Name: | Last Name: |
| Father's Date of Birth (mm/dd/yyyy): | | Father's SSN#: | |
| Choose one: ◯ Mother ◯ Guardian | First Name: | Middle Name: | Last Name: |
| Mother's Date of Birth (mm/dd/yyyy): | | Mother's SSN#: | |

| | | | |
|---|---|---|---|
| Home Phone: | Mother/Guardian Phone: | Father/Guardian Phone: | Email Address: |

| | | | |
|---|---|---|---|
| Mailing Address / Street: | City: | State: | ZIP Code: |
| Physical Address / Street: | City: | State: | ZIP Code: |

| | | |
|---|---|---|
| Marital Status (choose one): ◯ Married ◯ Single ◯ Divorced | What language do you speak at home: | Ethnicity *(see below)*: Father: Mother: |

| | | | |
|---|---|---|---|
| Father's Employer: | | Father's Employer Phone: | |
| Father's Employer Address / Street: | City: | State: | ZIP Code: |
| Mother's Employer: | | Mother's Employer Phone: | |
| Mother's Employer Address / Street: | City: | State: | ZIP Code: |

Please list one person that does not live with you that we can contact in case of emergency. Please list phone number including area code.

Name: Phone:

| | | |
|---|---|---|
| Patient's First Name: | Patient's Middle Name: | Patient's Last Name: |
| Sex: ◯ Male ◯ Female | Date of Birth (mm/dd/yyyy): | Ethnicity (see below): |

***Ethnicity: (A) Asian, (AI) American Indian, (B) Black/African American, (C) Caucasian, (H) Hispanic, (HW) Hawaiian, (L) Latin, or (O) Other***
(Please choose the race or ethnicity you most closely associate yourself with and choose only ONE for the purpose of this form.)

## Insurance Information (Page 2 of 2)

☐ I do not have insurance

| Primary Insurance Company: | | | ☐ Copay not required |
|---|---|---|---|
| Subscriber Name: | Date of Birth (mm/dd/yyyy): | Subscriber Social Security #: | |
| Insurance Effective Date: | Subscriber Insurance ID: | Subscriber Insurance Group #: | |
| Subscriber Insurance Address: | City: | State: | ZIP Code: |

| Secondary Insurance Company: | | | ☐ Copay not required |
|---|---|---|---|
| Subscriber Name: | Date of Birth (mm/dd/yyyy): | Subscriber Social Security #: | |
| Insurance Effective Date: | Subscriber Insurance ID: | Subscriber Insurance Group #: | |
| Subscriber Insurance Address: | City: | State: | ZIP Code: |

| Third Insurance Company: | | | ☐ Copay not required |
|---|---|---|---|
| Subscriber Name: | Date of Birth (mm/dd/yyyy): | Subscriber Social Security #: | |
| Insurance Effective Date: | Subscriber Insurance ID: | Subscriber Insurance Group #: | |
| Subscriber Insurance Address: | City: | State: | ZIP Code: |

☐ **I authorize assignment of benefits to Idaho Falls Pediatrics and authorize previously named clinic to release any information requested to receive payment.**

On occasion, you may wish to have your Child brought to the Clinic by someone other than a parent. The person or persons authorized to bring the child in must be 18 or over. Please list the names of those individuals who have your permission to bring your child in for assessment and or treatment. A day care worker or grandparent is an example of someone you would allow to bring your child in. If you do not want anyone to be authorized, please write NONE on the name line and sign at the bottom. The child listed on page one of this packet may be brought in for assessment and treatment by the following individuals:

| **Authorized Names** | **Relationship to Child** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

I authorize the release of information to the following person(s):

By signing below I also acknowledge that I received a copy of the Financial Policy and Summary of Notice of Privacy Practices (see last two pages in this packet).

Signature: _____ Date: _____

*Type your name to sign electronically.*

Witness:

## Medical Record Release (authorization to release medical information and/or medical records)

| Patient Name: | Date of Birth (mm/dd/yyyy): |
|---|---|
| | |

I authorize Idaho Falls Pediatrics to use or disclose Protected Health Information (PHI) contained in my Medical Records in the following manner:

## Send data to I.F. Pediatrics at 3067 Eagle Drive, Ammon, ID 83406 or fax to: (208) 552-7521

| Doctor's Name: | Phone: | |
|---|---|---|
| | | |
| City: | State: | ZIP Code: |
| | | |

## From:

| Person/Institution sending data: | Phone: | Fax #: | |
|---|---|---|---|
| | | | |
| Street Address: | City: | State: | ZIP Code: |
| | | | |

Please release the following Protected Health Information:

☐ All Records ☐ Chart Notes ☐ X-Rays ☐ Labs ☐ Mental Health Other:

The Protected Health Information is being used or disclosed for the following purpose(s): (If the patient is requesting the release, this may state "at patient's request")

(List specific purposes the Protected Health Information will be utilized)

## Expiration Date of Release

**This authorization is effective through _____ unless otherwise revoked or terminated by the patient's parents or guardian. NOTE: Please set this date to be one year from the date of filling out this form.**

- I understand that I have the right to revoke this authorization in writing by sending notification to the address above.
- I understand that when I revoke this authorization, it is not effective to the extent that the clinic has already relied on the use or disclosure of the Protected Health Information.
- I understand the Protected Health Information released pursuant to this authorization might be re-disclosed by the party who receives that information and may no longer be protected by federal or state law.
- The clinic will not base my treatment or payment on whether I provide an authorization for the requested use or disclosure, unless the provision of health care is solely for the purpose of creating Protected Health Information for disclosure to a third-party.
- I understand that I have a right to inspect or copy the Protected Health Information to be used or disclosed.
- I understand that I have a right to refuse to sign this authorization.
- If you have any questions concerning this form, please contact the clinic manger.

Signature: _____ Date: _____

*Type your name to sign electronically.*

Idaho Falls Pediatrics

Child's Name: _____

Today's Date: _____

# Social Determinants

In our efforts to improve your overall experience, our practice would appreciate you taking some time to answer a few questions. This information assists us in a better patient focused approach to your care. Circle the answer that is most appropriate to your situation.

1. Do you have transportation to make it to your medical appointments?
   - Yes
   - No
2. Do you have a permanent place of residence?
   - Yes
   - No
3. Do you have concerns that you do not have enough food for your family?
   - Yes
   - No
4. Do you have trouble paying for your healthcare needs, including prescribed medications?
   - Yes
   - No
5. Would you like one of our staff members to contact you to give you more information on any of the above? If yes, which one(s)?

_____

_____

Any additional children:

_____

_____

_____

_____

_____

_____

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# Our Financial Policy

Thank you for choosing Idaho Falls Pediatrics as your healthcare provider. We are committed to your children's treatment being successful. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

All patients must complete our information and insurance form before seeing the doctor. If you fail to provide us with the correct and complete insurance information in a timely manner, you may be responsible for the payment of a claim.

Any patient who has not been in our clinic over the past three years will be considered a NEW PATIENT.

## Minor Patients

**A guardian or adult with written permission from parents must accompany any child under 18 years of age.** Any unaccompanied minor will be denied treatment. The adult or guardian accompanying the minor is responsible for the full payment.

## Delinquent Accounts

If at any time your account is delinquent your account will be sent to MRS Collection Agency. We will not be able to schedule any appointments until the account is paid in full.

## Regarding Insurance

We will file your insurance as a courtesy to you and will do our best to maximize your benefits. It is your responsibility to understand your insurance benefits (what is and what is not covered). All co-pays are due at the time of service. Some insurance companies may charge a different co-pay or co-insurance amount when seeing a physician assistant rather than a doctor. Any remaining balance is you responsibility. If there are any questions regarding a claim please contact your insurance company. After you have contacted your insurance, if there is anything we can assist you with please contact our billing office.

We do contract with most insurance companies and will take their usual and customary allowances. If however, you have any insurance that we care not contracting with, you are responsible for the full remaining balance after insurance pays.

It is your responsibility to update any insurance changes. We will need to know the insurance company name, claims address, phone number, ID number, group number, policy holder name, date of birth, and social security number and the effective date of the insurance.

## Updated Information

It is your responsibility as well to make sure all addresses and phone numbers are kept up to date.

## Missed Appointments

If we are notified in a time that we can schedule another appointment for another patient there will be no charge. At a first missed appointment a reminder letter will be sent. For a second missed appointment there will be a $15.00 reinstatement fee due before any future appointments. For a third missed appointment there would be a $30.00 reinstatement fee due before any future appointments. If there is a fourth missed appointment you will be dismissed from our practice.

These financial options will meet the needs of most families in our practice. We want to be flexible in these changing times and we will do our very best to help you find a temporary financial solution that best fits the needs of your particular situation. We hope you will take into consideration the limitations we may have when making these arrangements. We value your business and are here to help you.

Thank you for taking the time to read and understand our financial policy. Please let us know if you have and questions or concerns.

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# HIPAA

## Summary of Notice of Privacy Practices

The notice of Privacy Practice contains a detailed description of how our office will protect your health information, your rights as a patient and our common practice in dealing with patient health information.

## Uses and Disclosures of Health Information

We will use and disclose your children's health information in order to treat your children or to assist other health care providers in treating your children. We will also use and disclose their health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to your children by us or other health care providers.

Finally, we may disclose your children's health information for certain limited operational actives such as licensing, accreditation and training of students.

## Uses and Disclosures Based on your Authorization

We will not use or disclose your health information without your written authorization except as stated in more detail in the Notice of Privacy Practices.

## Uses and Disclosures Not Requiring Your Authorization

In the following circumstances, we may disclose your health information without your written authorization:

- For purposes of public health and safety
- To government agencies for purposes of audits, investigations, and other oversight activists
- To government authorities to prevent child abuse or domestic violence
- To the FDA to report product defects of incidents
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders.
- When required by court orders, search warrants, subpoenas and as otherwise required by law

## Patient's Rights

As our patient you have the following rights:

- To have access to and or a copy of your health information
- To receive an account of certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence
- To request that we amend your health information
- To receive notice of your privacy practices

Idaho Falls Pediatrics

## Idaho Health Data Exchange

Idaho Falls Pediatrics has chosen to participate in the Idaho Health Data Exchange also known as IHDE. If you do not want your child to participate in IHDE and choose not to have their health care information shared with other medical providers involved with their care, you can opt out at anytime. In order to opt out, you need to complete and sign the IHDE "Request to Restrict Disclosure of Health Information" form and mail or fax it to IHDE. The opt out forms are on our website or you can request one at the front desk. You will receive a letter of confirmation upon completing the form. You will also need to contact directly any facility you wish to also restrict your child's information with. The IHDE form is available at our front desk and online. If you do not complete this form, we may share your child's protected health information with other participating health care providers involved in your care through IHDE interface. This is a very secure statewide internet-based health information exchange, with the goal of improving the quality and coordination of health care in the state of Idaho.

Thank you,

Idaho Falls Pediatrics