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Family Health Center
your medical home

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Welcome to Family Health Center!
We prioritize a team approach to healthcare with YOU at the center.

Here are a few things you need to know:

- Please complete your new patient paperwork **24 hours** prior to your appointment and return it to us via email or drop it off at the front desk. If we do not have your paperwork we may have to cancel your appointment.
- Please bring your insurance card and current ID with you to your appointment.
- Inform our front office staff if you are currently taking pain medications.
- Call your insurance and verify that we are designated as your PCP. If they do not know you have changed providers, they may not pay for your visit, meaning you get the bill for the full cost of the appointment.
- Bring copies of previous medical records with you if you have them. If not, we can assist in acquiring records.
- Visits for a motor vehicle accident must be paid for at the time of service. We do not bill attorneys or auto insurance carriers. Our billing department will be happy to provide you with a copy of the bill for your records.
- If you have a work-related injury, please call the office to provide us with the necessary information before we can schedule an appointment.
- Arriving 10+ minutes late to your appointment may result in rescheduling, please call the front office if you are running late.
- If you need to cancel or change your appointment, please call the office, and let us know as soon as possible.
  3 No Show appointments may result in being discharged from the practice.

Thank you for choosing Family Health Center for your medical needs!

Your New Medical Home

Family Health Center is a Patient-Centered Medical Home (PCMH) dedicated to the health and wellness of the patients we serve. Our certification as a PCMH means our physicians and staff are committed to comprehensive, personal healthcare centered around you! We want to ensure all of you and your family's medical needs are met.

Your Personal Physician

The relationship between you, your physician, and the care team is the driving force behind a PCMH. Your physician will provide medical care that is right for you based on evidence-based guidelines shown to improve health.

Your Care Team

Your physician will direct the care team to coordinate your care based on YOUR wants and needs.
To improve efficiency, the care team will plan for your appointment by:

- ✓ reviewing your medical chart for up-to-date forms.
- ✓ check for recent testing.
- ✓ ensure you are notified of results in a timely manner.
- ✓ coordinate your healthcare across all care settings including the medical office, hospital, behavioral health, testing facilities and other places where you may receive care.

If you are admitted to the hospital, you will receive a phone call from your care team upon your discharge to review your hospital stay, schedule you return for follow-up care, and discuss any questions or concerns you may have about your treatment or medications.

Your Health

In return, we ask that you be an active participant in your health by managing and monitoring aspects of your care.
You should:

- ✓ Tell us if there are any changes in your medications and bring a list if possible.
- ✓ Let us know if you are getting care from other healthcare providers, any hospitalizations, or ER visits.
- ✓ Tell us about any complementary and natural treatments you are getting.
- ✓ Provide a complete medical history so you get the best care possible.
- ✓ Identify previous doctors so our medical records staff can request important notes and test results.

Quality for you

As a PCMH we are committed to providing same day appointments and offering expanded hours to meet your needs. We will use our electronic health record to support the best care, quality, and safety by helping us to identify and provide for your needs. We are able to communicate with you electronically through our secure Patient Portal, along with sending you reminders for appointments and preventative or chronic care services due.

If you ever have any questions please just ask. Your care team is here to help!

Thank you for choosing Family Health Center as your Medical Home!

Last Name:	First Name:	MI:	DOB:
Preferred Name/Nickname:	SSN:		
Mailing Address:	City:	St:	Zip:
Cell Phone:	E-Mail Address:		
Insurance:			

Spouse, Partner, Emergency Contact and/or other contact to add to your chart

Last Name:	First Name:	MI:	DOB:
Cell Phone:	Relationship to Patient:		

Marital Status	**Preferred Contact**	**Ethnicity**	**Race**
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner	☐ Cell phone ☐ Home Phone ☐ E-Mail ☐ Patient Portal ☐ Mail Reminders and updates will be sent via email, text or portal unless you opt out	☐ Decline to specify ☐ Non-Hispanic ☐ Hispanic/Latino	☐ Decline to specify ☐ Indigenous American or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Gender Identity	**Sexual Orientation**	**Pronouns**	**Religion**
☐ Decline to specify ☐ Male ☐ Female ☐ Female to male ☐ Male to female ☐ Genderqueer	☐ Decline to specify ☐ Straight ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Don't know ☐ Other	☐ Decline to specify ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other	☐ Decline to specify ☐ Other ☐ Catholic ☐ Christian ☐ Jehovah's Witness ☐ Jewish ☐ Mennonite ☐ LDS ☐ Seventh Day Adventist

Consent for treatment:

1. By signing below, I give permission for Sandpoint Family Health Center to give me medical treatment.
2. I allow **Sandpoint Family Health Center** to file for insurance benefits to pay for the care I receive.
    a. I understand that **Sandpoint Family Health Center** may have to send my medical record information to my insurance company.
    b. That I must pay my share of the costs.
    c. That I must pay for the cost of services if my insurance does not pay or if I do not have insurance.
3. I understand that I have the right to refuse any procedure or treatment.
4. I have the right to discuss all medical treatments with my clinician.

X_____ _____

Signature of Patient/Guardian Date

Patient Financial Agreement

Thank you for choosing Sandpoint Family Health Center as your health care provider. We are committed to providing quality, comprehensive, and patient centered care while building a successful physician-patient relationship. An important part of that relationship is your clear understanding of our Financial Policies. To help you understand, we ask that you carefully read this policy. If you have any questions about this information, please ask to speak with a member of our billing staff.

Billing Insurance and Patient's Responsibility

In order to properly bill your insurance company, we require that you disclose all current insurance and demographic information. At each visit, please provide us with your insurance card and any changes to your name, address, or contact information. While every effort is made to collect from the insurance companies, patients are responsible for denied charges due to inaccurate insurance information.

We will do our best to help you understand your insurance benefits. However, it is ultimately your responsibility to know your benefits. The insurance company makes the final determination of your eligibility and benefits for services rendered, which may result in additional costs. We encourage you to contact your insurance company if you have any questions regarding your eligibility or benefits prior to your appointment.

If you have a concern regarding cost, please discuss any additional procedures with your physician *before* they are started.

Self-Pay or Private Pay

If you have no insurance coverage, we a $100 down payment is due when you check in and the balance due at the end of your appointment. W e will provide an estimate for the services requested at the time of scheduling. We offer a 50% discount on all professional charges to self-pay patients. This discount does not apply to procedures, labs, immunizations, or other in-office services. If a patient is unable to pay in full at time of service, a 25% discount will be applied to applicable services and a payment plan will be offered.

Payment Expectation and Collection Policy

Co-Pays are due at the time of your visit. If you do not pay your co-pay a $10.00 fee will be assessed. In the event you acquire a past due balance, we will make several attempts to notify you using the contact information you provide. If there is no response to our efforts within ninety (90) days, the balance will be turned over to our collection agency. We may not schedule any future appointments until your past due balances are paid in full. Any balance that is transferred to a 3rd party collection agency will have discounts removed. The balance transferred to the 3rd party collection agency will be FHC's full fee minus any payments that have been made.

My signature certifies that I have read and understand the contents of the Patient Financial Agreement.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

Acknowledgement of Notice of Health Information Practices

This Notice explains when we might use/disclose your health information, and includes some of the following examples:

When you give us permission to disclose your health information

- To aid in your treatment or to persons involved in your health care
- To help us or other health care providers get paid for services provided to you
- To public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- Right to ask that information about you not be disclosed to certain persons
- Right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- Right to ask that we communicate differently with you to ensure your privacy
- Right to look at and get a copy of most of your health information in our records
- Right to request that we correct health information in your record that is wrong or misleading
- Right to be notified when a breach of your health information has occurred
- Right to have us tell you whom we have disclosed your health information
- Right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services

I acknowledge that I have been given an opportunity to review this facility's Full Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have. (*This is NOT the complete Notice of Health Information Practices. If you would like the full copy it is available by request or by visiting our website at www.fhcsandpoint.com.)*

X_____ _____

Signature of Patient/Guardian Date

X_____ _____

Printed Name of Patient/Guardian Date

Patient Name: _____ DOB: _____

Main reason for your upcoming visit: _____

Which pharmacy will you be using? _____

Do you have a POST/Advance Directive? ☐ Yes ☐ No

Do you have a designated Durable Power of Attorney? ☐ Yes ☐ No If yes, who? _____

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots- Where?
- ☐ Cancer- What kind?
- ☐ Coronary Artery Disease
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes- Type 1 or 2?
- ☐ Heart Attack
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Renal Disease- Stage?
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Other:
- ☐ Other:
- ☐ Other:

Hospitalizations/Significant Injuries:

_____

_____

Surgery/Procedure History

- ☐ Appendectomy
- ☐ Back surgery
- ☐ Blood vessel surgery
- ☐ Colon/Rectal surgery
- ☐ Colonoscopy
- ☐ DEXA
- ☐ Heart Surgery- Type?
- ☐ Hernia Repair- Type?
- ☐ Hysterectomy- Type?
- ☐ Kidney surgery
- ☐ Knee Surgery- Type?
- ☐ Mammogram
- ☐ Organ transplant
- ☐ Pap Smear
- ☐ Prostate surgery
- ☐ Tonsillectomy
- ☐ Vaccines-Types?
- ☐ Vasectomy
- ☐ Other:
- ☐ Other:
- ☐ None

Details of surgeries/procedures:

_____

_____

Previous reaction to anesthesia (explain):

_____

_____

Date of last wellness physical, if known: _____

Family History

Member	Age(s)	Living?	Cause of Death (if applicable)
Mother			
Father			
Sister(s) #			
Brother(s) #			

Are you adopted? ☐ Yes ☐ No

Diseases in the FAMILY:

- ☐ Anxiety
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Addiction
- ☐ Bleeding problems
- ☐ Cancer- Types?
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mental illness
- ☐ Other:_____

Current Medications	Dosage/ How Often	Disease/Reason	Prescribed By

List of medications you have stopped taking in the last 12 months:

_____

_____

Allergies (Medication/Food/Environment)	Reaction

Reproductive (if applicable)

- **First day of last menstrual period (if through menopause, age of onset):** _____
- **If you are through menopause or over the age of 50, do you take any of the following pills:**
  ☐ Calcium ☐ Estrogen (Premarin) ☐ Progesterone (Provera)
- **Have you ever been pregnant?** ☐ Yes ☐ No
  - If yes, how many times have you been pregnant: _____
  - Number of live births: _____
- **Are you planning a pregnancy in the next 6-12 months?** ☐ Yes ☐ No
- **How many sexual partners have you had?** In the last 12 months: _____ In your lifetime: _____
- **If you are under age 55, what method of birth control do you use, if any?** _____

  If pills, what kind? _____ How long have you been on them? _____

Tobacco and Alcohol Use

- **Have you ever used tobacco?** ☐ Current ☐ Former ☐ None
  - Average number packs/day _____ Number years smoked _____
- **Are you planning to quit/have quit?** ☐ Yes ☐ No
  - If yes, when will you quit? _____ Or when did you quit? _____
- **Do you drink alcohol?** ☐ Yes ☐ No
  - If yes:
    - Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No
    - Have you felt guilty about drinking? ☐ Yes ☐ No
    - Have people annoyed you by nagging about your drinking? ☐ Yes ☐ No
    - Have you ever had a drink first thing in the morning to steady your nerves or help a hangover?
    - ☐ Yes ☐ No

Nutrition

Which of the following are included in your diet?

- **Grains/Starches** ☐ Many ☐ Some ☐ Few
- **Vegetables/ Fruits** ☐ Many ☐ Some ☐ Few
- **Dairy** ☐ Many ☐ Some ☐ Few
- **Meats** ☐ Many ☐ Some ☐ Few
- **Fried/ High-fat foods** ☐ Many ☐ Some ☐ Few
- **Sugar-Sweetened foods** ☐ Many ☐ Some ☐ Few

Physical Activity

Do you exercise? ☐ Yes ☐ No

- If yes, what activities: _____
- How many days per week?
  _____
- Duration (minutes) _____
- Exertion during exercise: ☐ Mild ☐ Moderate ☐ Intense

Patient Health Questionnaire (PHQ-9)				
Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching tv				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off any problem on this questionnaire so far, how difficult have these problems made if it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Is there anything else you would like us to know about your medical history?

_____

_____

_____

_____

Thank you for choosing Family Health Center to provide you with your medical care. We look forward to getting to know you and your family!