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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!

CONSENT FOR TREATMENT UNEMANCIPATED MINOR

Minor Patient: _____ **Birthdate:** ____/____/____

1. **Authority**. I am the parent, guardian or other person legally authorized by Idaho law to consent for health care services for the Minor Patient pursuant to Idaho Code § 32-1015.

2. **Consent for Treatment.** I voluntarily consent to and authorize PROVIDER GROUP (GROUP) and its employed or affiliated physicians, practitioners, and staff (collectively "Providers") to render the following health care services to the Minor Patient:

   ☐ **General Consent:** Medical evaluation, diagnosis and treatment; diagnostic services including lab tests or radiology procedures; prescription and administration of medications; counseling; and any other health care services as defined in I.C. § 32-1015 deemed reasonably necessary and appropriate by the treating Provider. This consent shall constitute a "blanket consent" within the meaning of I.C. § 32-1015(4)(a) and no further consent is required to authorize such health care services.

   or

   ☐ **Consent for Specific Care** [Describe]: _____

   _____

   _____

3. **Information.** The Provider has explained the nature of the proposed heath care services, alternatives, and their related risks and benefits, or I have waived my right to receive such information. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction or I have declined to ask such questions. If I require additional information concerning the health care services, I will contact GROUP or the Provider to discuss such services. I understand that the practice of medicine is not an exact science and no promises or guarantees have been made nor can they be made to me concerning the outcome of the health care services.

4. **Financial Responsibility.** I agree that I am ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with GROUP's Financial Policies. I will promptly pay any co-payments, deductibles, or other amounts not covered by applicable insurance or third-party payor program. I will cooperate with GROUP in obtaining reimbursement for the health care services from any third-party payor, and hereby assign to GROUP the right to submit claims for payment to third-party payers and retain such payments. To the extent allowed by law, I will remain responsible for any amount not paid by any third-party payor for health care services, including but not limited to costs relating to infectious, contagious or communicable diseases within the meaning of
   I.C. § 39-3801. If the Minor Patient's account becomes delinquent, I agree to pay interest and fees according to GROUP's Financial Policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys' fees, and court costs.
5. By signing below I give permission for Sandpoint Family Health Center to give my child medical treatment.
6. 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 these services if my insurance does not pay or if I do not have insurance. I understand that I have the right to refuse any procedure or treatment.
7. I have the right to discuss all medical treatments with my clinician.

I have read, understand, and agree to the foregoing, and I understand and acknowledge that GROUP and/or its Providers will render health care services in reliance on this consent.

Printed Name | Relationship to Minor Patient

Signature | Date

PERMISSION FOR TREATMENT OF MINOR

Patient Name: _____ Date of Birth: _____Date: _____

I give permission for the following people to seek and obtain medical care and treatment from Family Health Center for my child. This authorization is effective on the date signed.

Name	Relationship to Child	Phone #
Name	Relationship to Child	Phone #
Name	Relationship to Child	Phone #

This authorization: ☐ 1. EXPIRES ON: _____ OR ☐ 2. DOES NOT EXPIRE.
(DATE)

(I)(We), the undersigned, (Parents) (Legal Guardians) do hereby consent to and authorize Sandpoint Family Health Center to perform any necessary medical or surgical examination or treatment which is deemed advisable by a licensed medical practitioner at Sandpoint Family Health Center. I also understand that I am allowing the above-named caregivers the ability to make medical decisions for my child on my behalf, in my absence. This includes providing a history of present illness, disclosure of protected health information, and/or legal responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent/guardian mentioned above.

Financial Responsibility. I agree that I am ultimately responsible for payment for the health care services rendered to the Minor Patient and agree to comply with Sandpoint Family Health Center's Financial Policies. See Financial Policy for details.

_____ _____

Parent/Guardian Printed Name Date

_____ _____

Parent/Guardian Signature Relationship to Minor

Newborn New Patient Paperwork

Child's Last Name: _____ First Name: _____ Middle Initial: _____ Nickname: _____
Birthdate: _____ Age: _____ Gender: _____ SS#: _____

Child's Mailing Address: _____ City: _____ St: _____ Zip: _____

Patient Insurance: _____ Policy #: _____

Mother's Last Name: _____First Name: _____ Birthdate: _____ Phone:_____ _____

Mother's Address: _____ City: _____ St: _____ Zip: _____

Social Security #: _____ Email Address: _____

Employer's Name: _____ Work Phone: _____

Father's Last Name: _____First Name: _____ Birthdate: _____ Phone:_____ _____

Father's Address: _____ City: _____ St: _____ Zip: _____

Social Security #: _____ Email Address: _____

Employer's Name: _____ Work Phone: _____

Does this child primarily live with: ☐ Father ☐ Mother ☐ Other Adult _____

Does this child at times live with adults other than above? ☐ Yes ☐ No

Name _____ Relationship _____

Address _____ Phone_____

Preferred Contact	**Ethnicity**	**Race**
☐ Mail	☐ Hispanic/Latino	☐ American Indian or Alaskan Native
☐ Home Phone	☐ Non-Hispanic	☐ Asian
☐ Cell Phone		☐ Black or African American
☐ Patient Portal		☐ Native Hawaiian/Other Pacific Islander
☐ E-Mail		☐ White
		☐ Other

How would you like us to remind you about your child's future appointments? (Choose one)

☐ Voice Reminder (# we should call) _____

☐ Text message (# we should text) _____ *(Data message rates may apply-contact your carrier)*

☐ E-mail _____

How did you hear about us? ☐Employer ☐Family Member ☐Friend ☐Google/Web ☐Insurance Co ☐Previous Patient ☐Referral
☐ Other: _____

What doctor / clinic have/has taken care of this child in the past? _____

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/ Parent Date

X_____

Printed Name of Patient/ Parent

Pregnancy and Birth

(Only fill out if child is currently younger than 12 months old)

Where was baby born? ____
Birth Weight ________ Birth Length ________ Age of Mother at Baby's birth ______

Infant's gestational age: ☐ Full term ______ ☐ Preterm _____ If so, how many weeks ______ ☐ Post term ______

Type of Delivery: ☐ Vaginal _____ ☐ C-section _____ If so, reason _______________________________________

Were there any medical problems during the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor), Labor or Nursery? ____

Did baby experience any jaundice? ☐ Y ☐ N

Did baby have their newborn hearing test? ☐ Y ☐ N

Did baby have their PKU test (also known as Newborn Health Screening / Heel Poke) ☐ Y ☐ N

- -

Medications – List all medications your child takes, prescription and non-prescription, and the dosage		
☐ ***No Medications***		
Medication Name	**Dosage**	**Frequency**

Medication & Food Allergies – List all known allergies (drugs, food, animals, etc.)	
☐ ***No Allergies***	
Allergy	**Reaction**

Family History – Check if any family member(s) has had any of the following conditions and age of onset																	
Is child adopted? ☐ Yes ☐ No																	
Relationship to child	Alzheimer's	Anxiety	Alcoholism	Asthma	Blood Disorder	Depression	Diabetes	Heart Attack	Heart Failure	Hypertension	High Cholesterol	Renal Disease	Schizophrenia	Stroke	Thyroid Disorder	Cancer – list type and age below	**Alive?** *Mark Yes or No*
Father Age of onset?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		Cause of death and age:
Mother Age of onset?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		Cause of death and age:
Sister(s) Age of onset?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		Cause of death and age:
Brother(s) Age of onset?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		Cause of death and age:

Is there anything else you would like us to know about your child's 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!