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Family Health Center
your medical home

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Welcome to Family Health Center!

Where healthcare is a team approach with you and your child at the center of care.

Here are a few things you need to know:

- If your insurance requires you to designate a PCP please contact them ***prior to your appointment*** to let them know you have changed physicians or they may not pay for your visit. That means you may get a bill for the full cost of the visit.
- Please bring your insurance card and current driver's license with you to your appointment.
- Regarding your previous medical records – If you have copies, please bring them to your appointment. If not, we can further assist.
- Please complete your new patient paperwork **24 hours** prior to your appointment and return it to us before we see you.
- If you are taking pain medications, please talk with our front office staff.
- 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.
- **Please arrive 30 minutes before** your appointment.

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 patientswe 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 Physican

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, behavioural 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, make sure 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 care 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!

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Pediatric New Patient Paperwork Ages 3 Months-17 Years

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 _____

By providing your email address and/or mobile number, you consent to receive communications from our office via email and text message.

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

BLANKET CONSENT FORM FOR HEALTH CARE SERVICES FOR MINOR

PROVIDING BLANKET CONSENT IS OPTIONAL AND MAY, INSTEAD, BE GIVEN ON A CASE-BY-CASE BASIS. BLANKET CONSENT MAY BE WITHDRAWN BY A PARENT AT ANY TIME.

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 Sandpoint Family Health Center, PLLC (FHC) and its employed or affiliated physicians, practitioners, and staff (collectively "Providers") to render the following care:
    a. 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.

3. **Limitations and Exclusions:**
    a. This consent does not authorize abortion or any other services prohibited under local, state, or federal law.
    b. FHC believes that involving patients, parents/guardians and the treating provider in shared medical decision-making treatment plan(s) provides the most comfortable and transparent outcome, under Idaho Code § 32-1015 the following exceptions to the parental consent requirement exist:
        i. A minor is emancipated, meaning that the minor:
            1. Is or has been legally married;
            2. Is serving in the active military; and/or
            3. Has rejected the parent-child relationship, living on their own, and is self-supporting.
        ii. A medical emergency exists and parental consent cannot be obtained in time;

iii. The minor appears or represents that they are sick or injured and are seeking first aid services such as minor illness (excluding diagnostic testing), minor wound care, and general information on illness/injuries;
iv. The minor seeks care related to **time-sensitive evidence collection** for alleged physical violence;
v. The minor receives pregnancy detection, prenatal, or peripartum care (excluding abortion); and/or
vi. The minor has treatment that has been authorized by a court order.

c. I understand that the practice of medicine is not an exact science and no promises or guarantees can be made concerning the outcome of the health care services rendered. I can and am encouraged to ask questions regarding any care rendered.

4. **Access to Health Information:** Except as excluded under local, state, and/or federal laws, a child's health record is available to legal parent/guardians.

5. **Financial Responsibility:** I agree that:
   a. I am ultimately responsible for payment for the health care services rendered to the minor patient and agree to comply with FHC's financial policies.
   b. I will promptly pay any co-payments, deductibles, or other amounts not covered by applicable insurance or third-party payor program.
   c. I will cooperate with FHC in obtaining reimbursement for the health care services from any third-party payor and hereby assign to WHA the right to submit claims for payment to third-party payers and retain such payments.
   d. 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.
   e. If the Minor Patient's account becomes delinquent, I agree to pay interest and fees according to FHC's financial policies, including but not limited to reasonable costs of collection, collection agency fees, attorneys' fees, and court costs.
   f. Services provided by hospitals, diagnostic testing facilities (labs, imaging, etc.) may be billed separately.

6. **Revocation of Consent:** This blanket consent is voluntary and may be revoked at any time by providing written notice to FHC. Revocation does not apply to services already provided.

I have read, understand, and agree to the information provided in this consent. I confirm that I am providing this blanket consent form voluntarily and FHC has not pressured me into providing this blanket consent.

_____ Date: _____/_____/_____

Name

_____

Signature

_____

Phone Number

_____

Relationship to Minor Patient

PERMISSION FOR TREATMENT OF MINOR

Patient Name: _____Date of Birth:_____ Date:_____

I, the biological parent/legal guardian, 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.

You do NOT have to designate yourself, other biological parents, or legal guardians.

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

- We do offer unaccompanied minors to be seen by providers for ages 16-17. Please ask at the front desk for the form if you are interested.

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. On 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 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. A $100 down payment is due when you check in and the balance due at the end of your appointment. Please talk with our billing specialist if you would like to discuss a payment plan.

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.

X_____ _____

Signature of Parent/Guardian Date of Birth

X_____ _____

Printed Name of Parent/Guardian 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 Parent/Guardian Date of Birth

X_____ _____

Printed Name of Parent/Guardian Date

Last Name: _____ First Name: _____ DOB: _____

Reason for today's visit: _____

Regarding Pregnancy and Birth: ☐ Full Term ☐ Preterm If so, by how many weeks? _____

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

We there any medical problems during pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor)? _____

Preferred Pharmacy: _____

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**

Growth and Development

Are there any problems with the child's behavior in the home? ☐ Yes ☐ No If yes, please explain:

_____

_____

If child is old enough for school, are there any school problems (learning, social, behavioral, coordination)? ☐ Yes ☐ No If Yes, please explain:

_____

Has your child had any of the following?							
	Yes	No	Date		Yes	No	Date
Anemia				Heart trouble / murmur			
Appendicitis				Inability to get to sleep?			
Asthma				Kidney disease			
Bladder infection				Loss of urinary bladder control?			
Bleeding with bowel movements				More than six colds in a year?			
Bloody, red or brown urine				More than two earaches in a year?			
Broken Bones				Pneumonia			
Chickenpox				Rheumatic fever			
Chronic cough/frequent bronchitis				Shortness of breath with exercise?			
Concussion(s)				Stuffy nose most of the time?			
Convulsions/seizures				Treated for accidental poisoning			
Eczema/sensitive skin				Tonsil-Adenoid surgery			
Fainting spells				Trouble hearing			
Frequent bad stomachaches				Unconscious from an injury			
Frequent nightmares				Weak eye muscles (cross eyes or wall eyes)?			
Frequent urination?				Whooping cough			
Frequent vomiting?				Other serious injuries: _____			
Headaches more than twice a month?				Hospitalized for reasons other than those listed: _____			

Health and Safety					
	Yes	No		Yes	No
Does your child get regular dental cleanings?			Is the hot water temperature set to less than 125 degrees?		
Does your child use a car seat or seat belt all the time?			Do you have rules/limits for screen time?		
Are there smoke detectors in your home?			Are medicines or potential poisons out of reach?		
If there are guns in your home, are they locked up?			Is there an adult in your household who knows child CPR?		

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 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!