Blair Family Medicine

Patient Data			
Patient full name			Gender
Address	City	State	Zip
Home phone	Work phone		Marital Status
Birthdate	Age	Social Security Number	
Occupation		Employer	
Employer's address	City	State	Zip
Responsible Party/Spouse			
Name			
Birthdate	Age	Social Security Number	
Address	City	State	Zip
Employer			
Employer's address	City	State	Zip
Occupation		Business phone	
Relationship to patient			
Who should we contact in case of an emergency? Name		Phone	
Address		Relationship	
Insurance			
Primary insurance		Business phone	
Address	City	State	Zip
Policy holder's name		Policy number	
Subscriber name		Group number	
Secondary insurance		Business phone	
Address	City	State	Zip
Policy holder's name		Policy number	
Subscriber name		Group number	
Was this a work-related injury that is covered by Workers Compensation insurance? ☐ Yes ☐ No			
Name of Workers Compensation insurance			
Address	City	State	Zip
I hereby authorize the release of any medical information to process insurance claims for any services rendered to me by BLAIR FAMILY MEDICINE and authorize payment of medical benefits directly to them. I understand I am financially responsible for payment for medical services rendered from BLAIR FAMILY MEDICINE Signature: Date:			

Blair Family Medicine

Health History

Name	Date of birth	Date

Your answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best answer. Thank you.

Main reason for today's visit

Other concerns

How would you rate your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Review of Systems *Have you ever had any of the following (check all that apply)*

Constitutional

☐ Unexplained weight loss/gain

☐ Recent fever/sweats

☐ Unexplained fatigue/weakness

☐ Recent chills/cold sweats

Cardiology

☐ Chest pains/discomfort

☐ Palpitations

☐ Decreased exercise tolerance

Dermatology

☐ Rash

☐ New or change in mole

Endocrinology

☐ Cold/heat intolerance

☐ Increase thirst/appetite

ENT

☐ Change in hearing

☐ Congestion

☐ Sinus pain

☐ Sore throat

Hematology/Lymph

☐ Unexplained lumps

☐ Easy bruising/bleeding

Genitourinary

☐ Painful/bloody urination

☐ Leaking urine

☐ Night time urination

☐ Discharge: penis or vagina

☐ Concern with sexual functions

Gastroenterology

☐ Heartburn/reflux

☐ Bloody stools

☐ Change in bowel movement

☐ Nausea/vomiting/diarrhea

☐ Pain in abdomen

Musculoskeletal

☐ Muscle/joint pain

☐ Recent back pain

☐ Weakness

☐ Swollen joints

Neurology

☐ Memory loss

☐ Headaches

☐ Fainting

☐ Numbness/tingling in hands/feet

☐ Loss of balance

Ophthalmology

☐ Change in vision

☐ Eye pain

Psychology

☐ Anxiety/stress

☐ Sleep problems

Respiratory

☐ Cough/wheeze

☐ Coughing blood

☐ Short of breath with exertion

☐ Pain with breathing

Women

☐ No periods

☐ Heavy periods

☐ Painful periods

☐ Irregular periods

☐ Unusual vaginal bleeding

Date of last period:

_____

Menopause age:

_____

In the past month have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?

☐ Yes ☐ No

Do you have an Advanced Care Plan (Living Will)

☐ Yes ☐ No

Who is your surrogate decision maker?

Name: ☐ None

Blair Family Medicine

Health History

Allergies *Do you have allergies or reactions to the following, please list*

Medications	Reaction	Foods	Reaction

Medication

Prescriptions and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day	Medication/Vitamin Supplement	Dose/Strength (e.g., mg/pill)	How Many Times Per Day

Medical History

Major illnesses: (i.e., high blood pressure, high cholesterol, depression, etc.)	Year of diagnosis	Doctor treating
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Surgeries

Surgeries	Year of surgery	Reason for surgery
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Blair Family Medicine

Health History

Family History	
Mother ☐ Living ☐ Deceased	Ailments
Father ☐ Living ☐ Deceased	Ailments
# brothers alive: _____ # brothers deceased: _____	Ailments
# sisters alive: _____ # sisters deceased: _____	Ailments
# children alive: _____ # children deceased: _____	Ailments

Social History

Tobacco use

Cigarettes ☐ Never ☐ Quit date: _____ ☐ Current smoker: _____ packs/day; # of years _____

Other tobacco; ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol use

Do you drink alcohol? ☐ Yes ☐ No # drinks/week _____

Is alcohol use a concern for you or others? ☐ Yes ☐ No

Are you satisfied with your weight? ☐ Yes ☐ No	How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Socioeconomics

Occupation

Employer

Marital status

☐ Single ☐ Partner/Married ☐ Divorced ☐ Widowed

Women Health History

# Pregnancies	# Deliveries	# Abortions	# Miscarriages

Exercise			
Do you exercise regularly? ☐ Yes ☐ No		If you do not exercise, why not?	
If yes, what kind of exercise:		How long (minutes)	How often?

Signature

Patient signature	Date

BFM_Adult_Health_History Rev 3/18

Blair Family Medicine

Office and Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial*. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see our patients. If you are not able to keep an appointment, we require 24-hour notice.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time; however, emergencies do occur, and we appreciate your understanding.
4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered. During routine physical examinations, if additional medical problems are found or discussed, including any abnormalities or preexisting problems, your insurance will be billed for those services. **Based on your medical plan benefits you may be responsible for additional co-pay, deductibles or out of pocket expenses. These charges will be your responsibility.**

Initial:_____

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect or you fail to update your information, you will be responsible for payment of the services provided.**
2) If we are your primary care physician, make sure your name or phone number appears on your card if applicable. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to out of pocket expenses, covered services and participating laboratories. For example:
    a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
    b. During routine physical examinations, if additional medical problems are found or discussed; including any abnormalities or preexisting problems your insurance will be billed for those services. **Based on your medical plan benefits you may be responsible for additional co-pay, deductibles or out of pocket expenses. These charges will be your responsibility.**
    c. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company may not pay, and you will be responsible for payment.
    d. If your insurance has a dedicated laboratory, it is your responsibility to have your labs drawn at the appropriate site.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. Please confirm all referrals and authorizations are in place prior to your appointment or you may be responsible for payment.

Initial:_____

Blair Family Medicine

Referrals/Prior Authorizations

1) Advanced notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, we must approve referrals before they are issued. If you have not been seen in the last 6 months you may be asked to make an appointment with your PCP before a referral is approved.
4) It is your responsibility to know if a written referral or authorization is required to see a specialist, whether preauthorization is required prior to a procedure, and what services are covered. Please confirm all referrals and authorizations are in place prior to your appointment or you may be responsible for payment.

Initial:_____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service.
3) Self-pay patients are expected to pay for services in **FULL** at the time of the visit.
4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit.
5) Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Your remittance is due within **10** business days of your receipt of your bill.
6) If previous arrangements have *not* been made with our billing office, any account balance outstanding longer than 90 days will be forwarded to a collection agency.
7) For scheduled appointments, past due balances must be paid at the time to the visit.
8) If you participate with a high-deductible health plan, you may be required to pay for the visit if your deductible has not been met.
9) We accept cash, checks, Visa, and MasterCard credit and debit.
10) A fee will be charged by "CHECKWAY" for any checks returned for insufficient funds.

Initial:_____

Forms

1) Forms are subject to a form fee for completion. Payment is due when the forms are dropped off. We require 3-day turnaround time.

Initial:_____

Blair Family Medicine

Transfer of Records

1) If you transfer to another physician, we will provide a copy of your medical record to your new physician, free of charge, as a courtesy to you. A copy of the medical records will be mailed directly to the physician office listed on the medical record release form. Please allow 7-10 business days for processing.
2) A copy of your complete record is available for:
    a. $14.00 for the first 10 pages.
    b. $0.50 for each additional page 11-40
    c. $0.33 for each additional page over 40

Initial:_____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly.
2) **To expedite your request please call your pharmacy to request a refill**

Initial:_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name_____Relationship_____

Responsible Party Member's Signature_____

Date_____

Blair Family Medicine

Medicare Authorization

Name of beneficiary	Medicare number
I request that payment of authorized Medicare benefits be made either to me or on my behalf to BLAIR FAMILY MEDICINE for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents any information needed to determine these benefits or the benefits payable for related services.	
Signature	Date

Medicare Medigap Assignment Authorization

Medigap policy number
I request that payment of authorized Medigap benefits be made either to me or on my behalf to BLAIR FAMILY MEDICINE for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to be released to: _____ **(Name of Medigap Policy)** any information needed to determine these benefits or the benefits payable for related services.

Signature	Date

BFM_Medicare_Authorizatio_BFM Rev 3/18

NOTE: Your signature under “Medicare Authorization” on this form will allow our office to submit claims to Medicare on your behalf without requiring your signature on each Medicare claim form. If you have a Medigap policy in addition to Medicare, please complete both sections of this form.

Blair Family Medicine

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Our goal is to take appropriate steps to safeguard any medical or other personal information that is provided to us. We are required by law to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

Who Will Follow This Notice

This notice describes the practices of our employees and staff as well as:

- Our billing agency
- Any health care professional or student authorized to enter information into your medical record maintained at our facility

The individuals identified above will share protected health information with each other, as necessary to carry out treatment, payment, or health care operations as described in this Notice.

Information Collected About You

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number
- Information relating to your medical history
- Your insurance information and coverage
- Information concerning your doctor, nurse or other medical providers

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" – such as the referring physician, your other doctors, your health plan, and close friends or family members.

How We May Use and Disclose Information About You We may use and disclose personal and identifiable health information about you in different ways. All of the ways in which we may use and disclose information will fall within one of the following categories, but not every use or disclosure in a category will be listed.

For Treatment. We will use health information about you to furnish services and supplies to you, in accordance with our policies and procedures. For example, we will use your medical history, such as any presence or absence of heart disease, to assess your health and perform requested ultrasound or other diagnostic services.

For Payment. We will use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical

condition so that it will pay us for the services that we have furnished you. We may also need to inform your payer of the tests that you are going to receive in order to obtain prior approval or to determine whether the service is covered.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for accreditation organizations, auditors or other consultants to review our practice, evaluate our operations, and tell us how to improve our services. We may remove identifiable information to protect your privacy.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you, including but not limited to:

- As required by law
- Food and Drug Administration
- Funeral Directors and Coroners
- Organ and Tissue Donation Organizations
- Workers Compensation Agents
- Correctional Institutions
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- In reports about child abuse, domestic violence or neglect
- Military Command Authorities
- Health Oversight Agencies
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- For legal proceedings including judicial or administrative proceedings and in certain conditions in response to a subpoena, discovery request or other lawful process
- To prevent a serious threat to your health and safety or the health and safety of others

We may use or disclose certain personal health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your protected health information to prepare or analyze a research protocol and for other research purposes.

Our Business Associates. We sometimes work with outside individuals and businesses who help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must guarantee to us that they will respect the confidentiality of your personal and identifiable health information.

Individuals Involved in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your “circle of care” – such

as your spouse, your other doctors, or an aide who may be providing services to you. Although we must be able to speak with your physicians or health care providers, you can let us know if we should not speak with other individuals, such as your spouse or family.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you should schedule an appointment.

Treatment Alternatives. We may use and disclose your personal health information to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.

Other Uses and Disclosures of Personal Information

Most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information require authorization.

We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization. We will be unable to take back any disclosures already made based upon your original permission.

Individual Rights

Request Restrictions. You have the right to ask for restrictions on the ways in which we use and disclose your medical information beyond those imposed by law. We will consider your request, but we are not required to accept it.

Confidential Communications. You have the right to request that you receive communications containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.

Copy of Records. Except under certain circumstances, you have the right to inspect and copy medical and billing records about you. If you ask for copies of this information, we may charge you a fee for portable media, copying and mailing.

Amend Records. If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or correct the missing information. Under certain circumstances, we may deny your request.

Accounting of Disclosures. You have a right to ask for a list of instances when we have used or disclosed your medical information for reasons other than your treatment, payment for services furnished to you, our health care operations, or disclosures you give us authorization to make. If you ask for this information from us more than once every twelve months, we may charge you a fee.

Health Plan Disclosure Restriction. You have a right to restrict certain disclosures of protected health information to a health plan when you pay out of pocket in full for the health care service provided.

Breach Notification. You have the right to be notified following a breach of unsecured protected health information if the breach affects you.

Marketing. You have the right to restrict certain uses and disclosures of protected health information for marketing purposes which may result in remuneration by a third party to Blair Family Medicine.

Copy of Notice. You have the right to a copy of this Notice in paper form. You may ask us for a copy any time. This notice is also available electronically on our web site at www.blairfamilymed.com

To exercise any of your rights, please contact us in writing at HIPAA Compliance Officer, Blair Family Medicine, 2265 E. Sunnyside Rd., Idaho Falls, ID 83404.

Blair Family Medicine

Changes to this Notice

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this Notice, the revised Notice will be posted in our facility and on our website. In addition, you may request a copy of the revised Notice at any time.

Complaints, Comments, and Additional Information

If you have any complaints about our Privacy Policy, you may contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). You may also contact us for the purpose of expressing your concerns, to provide your comments or to obtain additional information about this Privacy Policy to HIPAA Compliance Officer, Blair Family Medicine, 2265 E. Sunnyside Rd., Idaho Falls, ID 83404 (208) 3574633.

Patients will not be retaliated against or penalized by us for filing a complaint.

This Privacy Policy is effective January 1, 2016. *Rev 4/18*

Blair Family Medicine

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Notice of Privacy Practices from Blair Family Medicine concerning how the use and disclosure of Protected Health Information will be handled by the practice.

Patient name (please print)	
Patient/Guardian signature	Date
If guardian, print name	Relationship to patient

BFM_Privacy_Practices Rev 4/18

Blair Family Medicine

Communication Consent

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

_____ (Patient initials) Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____. 000 - 0000.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details)

2001 S. Woodruff Suite 15B, Idaho Falls, ID 83404 o: (208) 357-4633 www.blairfamilymed.com

Blair Family Medicine

MEDICAL RECORD REQUEST FORM

TO_____
DOCTOR OR HOSPITAL ADDRESS

I_____ HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
PRINT PATIENT'S NAME DATE OF BIRTH

Blair Family Medicine
2001 S. Woodruff Suite 15B, Idaho Falls, ID 83404
Tel (208) 357-4633 Fax (208) 419-0690

☐ Complete Medical Records and Images in Your Possession
OR
☐ Diagnostic Records ☐ Treatment Records ☐ Radiology Report and Images ☐ Clinic ☐ Visit Notes ☐ Other_____

For the purpose of:
☐ Treatment/Continued Medical Care/Medical Facility ☐ Other: _____

I understand that this Record Release form authorization will expire one year from the date of signing unless I indicate an earlier date of event here:

_____

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I can revoke that authorization at any time. The revocation must be made in writing to the facility releasing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- The provider/facility will not condition my treatment on whether I sign the authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form.

Please indicate your legal relationship:
☐ Parent ☐ Legal Guardian

Signature _____ Date _____

Medical Records Request Rev 4/18