PATIENT INFORMATION

New ___ Update ___ Provider:____________

Patients Legal Name ____Today's Date__________

Address______________________________________ Zip Code____________ Home Phone______________
(Leave Message Y/N)

Sex_________ Age_________ D.O.B_____________ SSN____________________ Cell Phone___________________
(Leave Message Y/N)

Marital Status____ Work Phone__________________
(Leave Message Y/N)

Employer's Name_________________________________ Occupation______________________________

Spouse/Responsible Party___________________________ D.O.B____________ Relationship _______________

Address (if different)____ Phone____________________

Patient's Emergency Contact____ Phone____________________

Emergency Contact Relation to Patient____

Patient's Pharmacy______________________________________ Patient's Previous PCP___________________

How Did You Hear About Our Office?____

GENERAL INFORMATION ON PAYMENT AND FINANCIAL POLICY

Do you have health insurance? _____Yes _____No. Please provide us with your insurance card so that we may copy it for our records.

We ask for payment at the time of service unless other plans are pre-arranged. If you do not provide your insurance card at the time of service you will be considered a cash pay patient and payment is due at the time of service. **If you do not pay at the time of service no discount will be offered.**

Please note that if your insurance does not cover all wellness screenings that are standard of care per the AAFP, then YOU MAY OWE AN ADDITIONAL AMOUNT after insurance processes the claim. Also, if a provider addresses and treats other concerns outside the scope of a well check in order to save you time and prevent a separate visit, then WE MAY BILL FOR THIS ADDITIONAL SERVICE.

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers as a courtesy to you. Please present your insurance card along with the completed information. We can **NOT** bill insurance without a copy of your card(s). You must supply the correct information. Please remember that you are responsible for all charges regardless of insurance coverage.

I request that payment of authorized Medicare/Insurance Benefits be made either to me or on my behalf to Magic Valley Family Practice for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance company or Medicare/Medicaid or their agents, any information needed to determine these benefits or the benefits payable for related services.

Although we have lab services in our facility, these are NOT included in our billing.

No-Shows and Cancellations: We require a 24 hour minimum notice of cancellation. All other cancellations will be deemed a no show and are subject to a $25 fee. If you have three concurrent no-shows you will not be rescheduled. Please help us to serve you better by keeping your regular scheduled appointments.

AUTHORIZATION AND AGREEMENTS FOR THE TREATMENT

CONSENT TO TREATMENT: I understand that medical treatment will be performed by independent providers, their assistants, and employees of Magic Valley Family Practice. I hereby give my authorization and consent to treatment and procedures and certify that no guarantee or assurance has been made as to the results of such treatments or procedures.

AGREEMENT TO PAY FOR SERVICES: For the care and treatment provided to the patient, I promise to pay Magic Valley Family Practice all charges for services rendered to or on behalf of the patient.

I HAVE READ AND UNDERSTAND THE ABOVE ACKNOWLEDGMENTS AND AGREEMENTS

SIGNATURE____DATE__________________________

PATIENT PORTAL POLICIES AND PROCEDURES

Magic Valley Family Practice in partnership with NextGen, our EHR vendor, is happy to offer a secure patient portal. The patient portal is an internet based system designed to provide a secure HIPPA compliant method of communication between the office staff and our patients. The Patient Portal is an optional feature that is being provided to our patients at their request. After logging into the Patient Portal using a unique username and password, a patient can conveniently access and review portions of their electronic medical record.

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Email for Portal Access

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the full “Notice of Privacy Practices”

______________________________	______________________________
Signature of Patient	Date
______________________________	______________________________
Name or Signature of Legal Representative	Relationship

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Document Reason for Refusal of Signature

IN SUMMARY

The organization Health Care Arrangement (OHCA) of Magic Valley Family Practice will provide each patient with a copy of their “Notice of Privacy Practices.” The OHCA will use and disclose health information about you for the purpose of treatment and/or alternatives, payment and to individuals involved in your care of payment of your care and for health care operations.

Unless you object, your name, location, general condition will be kept in our office and may be given to anyone who asks for you by name. We may also use your information for appointment reminders or health related benefits and services. Other uses of your information are described in the “Notice of Privacy Practices.”

You have the right to: Inspect and copy, amend, request an account of disclosures and request restriction on how we use or disclose your information, you also have a right to request confidential communications.

We reserve the right to change the “Notice of Privacy Practices.” We also reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information received in the future. We will post a copy of the most current “Notice of Privacy Practices.” Please read the full notice that has been given to you, it explains our privacy practices in further detail

2167 Village Park Ave. Ste 300 / Twin Falls, ID 83301 / (208)733-5117 / f (208)733-5143

PROTECTED HEALTH INFORMATION RELEASE: PATIENTS 18 YEARS AND OLDER

Patient Name: ____ DOB: ____________________

- o Only release information to me personally
- o You have my permission to speak with my spouse/significant other about my medical care and test results.
  Spouse/significant others name: ________________________ Phone: ___________________
- o You have my permission to talk with my children or other family members involved with my medical care
  Name: __________________________________ Phone: ______________________________
  Name: __________________________________ Phone: ______________________________
  Name: __________________________________ Phone: ______________________________
  Name: __________________________________ Phone: ______________________________
- o Other (please describe):____

Signature____ Date______________________________________

(Initials) ______ I acknowledge that this release expires 3 years from date signed