PATIENT INFORMATION

Last Name:	First Name:	MI:	Previous Name (if applicable)
Date of Birth:	Sex:	Social Security #:	
Mailing Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Other:	
Occupation:	Employer:	Work Phone:	
Marital Status:	Spouse's Name:	Spouse Phone Number:	
Spouse's Employer / Occupation:	Spouse's Social Security #:		
Emergency Contact:	Phone #:	Relationship:	
Email:	Pharmacy & Location:		

RESPONSIBLE PARTY

If the patient is a minor, the parent or guardian bringing in the patient will be listed as the guarantor.

Last Name:	First Name:	
Date of Birth:	Social Seculty #:	Phone:
Address of Person Responsible		
City/State/Zip:	Relationship to Patient:	

INSURANCE

If you provided a copy of your card only fill out insurance company's name.

Insurance Company Name:		
ID#:	Group #:	
Subscriber/Employee Name:	Relationship to Patient:	
Date of Birth:	Social Secuity #:	Sex:
Secondary Insurance (if applicable)		

The information that I have provided is complete and true to the best of my ability:

Signature of Responsible Party: ______________________________ Date:__________

Printed Name of Responsible Party: ______________________________ Date:__________

OFFICE POLICIES- PT COPY

Thank you for choosing Active Family Healthcare. The following information is provided for your convenience as well as the convenience of our office.

PLEASE INITIAL THE FOLLOWING:

______ **Late Policy**
We make every effort to remain on schedule. In order to do this we ask that patients are 10-15 min early for their appointments. Patients that arrive more than 10 minutes after their scheduled time will be canceled and rescheduled; dependent on the discretion of the provider's schedule.

______ **No-Shows & Cancelation**
Established patients may be charged a $50 "No-Show" fee if the office has not been notified at least 12 hours before cancelation of appointment.

_____ **Prescription Refills**
Please notify your pharmacy **one week** prior to being out of medicine and ask them to send a request electronically. We require 48-72 hours notice for prescription refills to be processed. If you are requesting to refill a narcotic prescription a urine sample may be needed as well as an appointment.

_____ **Insurance/ Co-Pays/ Deductibles**
It is patient's responsibility to provide Active Family Healthcare with the correct insurance information. It is crucial that you know/understand the contract you've signed with your insurance provider. Our staff will interpret insurance information to the best of their ability to provide you with the most accurate information regarding your copay and deductible. **Your copay or payment towards your deductible is required upon date of service.**

_____ **Past Due Accounts**
If you have a past due balance on your account you will be expected to pay the full balance or a minimum of $50 toward the balance before you are seen. This does not include your copay or deductible amount for that day's appointment. All delinquent accounts beyond 120 days will be forwarded to a collection service for legal action.

_____ **Emergencies / After Hours**
If you have a life-threatening emergency, call 911 or go to the nearest emergency room immediately. If you feel this is of an urgent matter that is not life threatening and can not wait till the next business day, you can **call our on-call provider at 208-651-5101.**

_____ **Billing**
Please direct all billing questions to our billing company Pacific Medical Revenue, 1-855-621-8250.

_____ **Office Etiquette**
When at the office please silence your cell phone, no unattended children, and no guns or knives in our office.

FINANCIAL AGGREEMENT/ RELEASE OF INFORMATION/OFFICE POLICIES

I request that payment of authorized Medicare or other insurance benefits be made to Active Family Healthcare for any services furnished to me by AFH. I authorize Active Family Healthcare to furnish all requested medical information of the persons or entity names above if requested by my insurance company in order to process my claim. I acknowledge that I have reviewed Active Family Healthcare's policy and procedures. I understand that regardless of my insurance status, I am solely responsible for payment of any professional services rendered to me, or on my behalf, whether or not paid by my insurance company. I acknowledge I have received and read a copy of the AFH office polices.

Signature of Patient or Legal Guardian: ______________________ Date:__________

Print Name:______________________

Relationship to Patient: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTIVCES

I hearby acknowledge that I have received or have been given the opportunity to receive a copy of AFH Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be made available to me upon request.

Signature of Patient or Legal Guardian: ______________________ Date:__________

Print Name:______________________

Relationship to Patient: ______________________

AUTHORIZATION FOR ACTIVE FAMILY HEALTHCARE TO UTILIZE INFORMATION AS DESCRIBED IN PRIVACY NOTICE

Please indicate by signature below that you are authorizing us to use private patient Informaition as indicated in our Notice of Privacy Practives. This is not a change in how we have historically used your information. New laws require to disclose how we use this information.

Signature of Patient or Legal Guardian: ______________________ Date:__________

Print Name:______________________

Relationship to Patient: ______________________

PATIENT'S CONSENT FOR ACTIVE FAMILY HEALTHCARE TO SHARE PROTECTED HEALTH INFORMATION WITH:

NAME:	RELATIONSHIP:
______________________	______________________
______________________	______________________
______________________	______________________

Signature of Patient or Legal Guardian: ______________________ Date:__________

PATIENT INFORMATION SHEET

NAME: ____________________ GENDER: __________ DOB: __________ DATE: __________

ALLERGIES: ____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD
Alcoholism
Allergies, Seasonal
Anemia
Anxiety
Arrhythmia (irregular heart beat)
Arthritis
Asthma
Bipolar
Bladder Problems / Incontinence
Bleeding Problems
Cancer: __________
Headaches
Crohn's Disease

COPD/ Emphysema
Dementia
Depression
Diabetes: 1 or 2
Diverticulitis
DVT (Blood Clot)
GERD (Acid Reflux)
Glaucoma
Heart Disease
Heart Attack (MI)
Hiatal Hernia
High Blood Pressure
Kidney Stones
Kidney Disease

High Cholesterol
HIV
Hepatitis
Irritable Bowel Syndrome
Lupus
Liver Disease
Macular Degeneration
Neuropathy
Osteopenia/Osteoporosis
Parkinson's Disease
Peripheral Vascular Disease
Peptic Ulcer
Psoriasis
Pulmonary Embolism (PE)

Rheumatoid Arthritis
Seizure Disorder
Sleep Apnea
Stroke
Thyroid Disorder
Ulcerative Colitis

Last Menstrual Period	Date:	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

____

Surgical History: Please list all prior surgeries and approximate dates performed.

______________________ ______________________

______________________ ______________________

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: __________

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: ______________ Amount/day: _________ Number of Years: _______

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _________

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: ____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

____

____

FAMILY HISTORY:

FATHER: Living: Age __________ Deceased: Age __________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

MOTHER: Living: Age __________ Deceased: Age __________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

SIBLINGS:

____

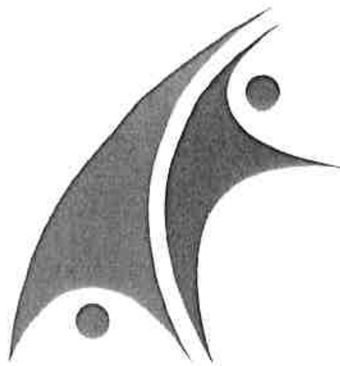
____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

____

____

Patient Signature: ______________________________ Date: ________________



ACTIVEFAMILY
HEALTHCARE

Welcome to Active Family Healthcare!

We are very excited that you've chosen to join our clinic. We pride ourselves in being a different option in healthcare for our fellow North Idahoans. Your care and satisfaction are of top priority to us. Our team is highly trained, well educated, friendly and available to serve your every need. Our goal is to make sure your time spend with us is a pleasant as possible.

We appreciate the opportunity to take care of the health needs of you and your family.

Jennifer Fletcher, FNP   Jessica LaPlante, FNP   Whitney Hall, FNP

Policy and Procedures

Welcome-

The goal of this office is to provide the best possible medical care in a timely manner and in a pleasant atmosphere. If you have any suggestions how we might improve on this, we appreciate any input you might have. In order to provide the best possible care in the timeliest manner for our patients, the following office policies have been established.

Appointments Policy

Every effort is made to remain on schedule. In order to keep the schedule on time, being more than 15 minutes late for an office appointment will mean cancellation for that appointment and rescheduling at a later date. You will only be seen for the problem you are scheduled for. Another appointment will have to be made to address other issues unless time allows.

- If you miss a new patient appointment twice and do not notify the office, you will not be rescheduled unless you pay a re-booking fee.
- Established patients may be charged a $25 "no-show" fee if the office has not been notified of the need to cancel an appointment 24 hours prior.
- Repeated "no-shows" will result in being discharged from our office, at providers discretion.

Walk-in appointments are discouraged as they create a scheduling confliction. We ask that you please call first so we can advise you on the best approach to ensure appropriate medical care.

"Nurse Only" appointments: Most appointments are scheduled only if you have an order in your chart to have a service provided that they have already addressed within a certain period of time. (i.e., blood draw, injection, immunization).

Emergencies/after hours: If you have a life threatening emergency, you should call 911 or go immediately to the nearest emergency room. If you feel this is of an urgent matter that is not life threatening, and can't wait until the next business day, you can call our on-call provider at 208 651-5101.

Financial Information

The financial responsibility for services rendered rest with the patient or responsible party, regardless of any insurance coverage. We see a variety of different insurance plans, it is impossible for us to know all the covered benefits, copays and deductibles for each individual plan. While it is our intention to assist you, it is still your responsibility to ensure that all service rendered are paid in full.

We will bill all health insurance companies that we are contracted with as long as you provide the correct billing information (a copy of your card works best). **Co-payment** is due at the time of service however, if you do not have a copay listed, you are required to pay $30 at the time of service. We suggest you call the number on the back of your card and know your co-pay and deductible amount. It is your responsibility to know your coverage, make sure you have us listed as your primary provider, and be sure our office is contracted with

your insurance. If your Insurance is updated or changed, it is your responsibility to inform us. If we bill old information, a re-billing charges might apply.
If you are having our providers complete any "form" for you, be sure your portion is filled out and signed.
When referring you to a specialist and your insurance requires a special referral or prior authorization, please inform us before we schedule that appointment

Nonsufficient Funds/Collection Account-We attempt every effort to work with you to make some type of payments. We send reminder letters and final notice before sending to collection. All nonsufficient funds will be subject to a $20 fee. If your account is turned over to collections, you can become a patient again if balance is paid in full and your provider allows re-admission in to practice. Our hope is not to let it go this far and have some good communication on a payment plan.

3rd Party Claims.

If you are involved in a civil suit, auto, home or business owner's accident and are seeking payment from the responsible party, we expect payment at the time of service. We do not bill the responsible party's insurance or attorney for your services in these situations due to the length of time it takes to settle these claims. We will provide you a copy of your statement so you can bill the responsible party.

Patients without Insurance Coverage

If you do not have insurance, payment at the time of service is required. We offer a 30% discount to patients paying for their services in full at the time of their visit. Short-term payment plans are available but must be requested prior to the services being performed. When payment plans are instituted, no discounts apply.

Workers Compensation Claims

If you are seeing one of our providers for an injury that occurred during the course of your employment, please be sure to notify the receptionist that your injury is "work-related". Please be advised that our office is obligated by law to report all work-related injuries to the Department of Labor and Industries. If your employer or their insurance carrier denies your claim, you will be held financially responsible for all charges incurred for services rendered on your behalf. Washington and Idaho worker's compensation insurance is accepted. You must provide our office with the following information at the time of your first appointment

- Name and address of your employer worker's compensation carrier
- Exact date of your injury.
- Claim number, case manager's name and contact information

If you ever receive a bill that you feel is incorrect, please notify our billing company, Pacific Medical Revenue, 1 855-621-8250 as soon as possible so that they can address the issue.

Medical Records Policy

Active Family Healthcare is happy to provide each patient with one complete copy of their chart free of charge. If additional copies of the chart are requested by the patient, there will be a charge per page and payment will need to be received before records are released.

Please allow 7 to 10 working days for your medical record release request to be processed. If you have a situation in which you need your copies released sooner, please contact us and they will try and accommodate your request.

Prescription Refills Policy We require 48-72 hours for prescription refills to be processed. We request that you call your pharmacy first and ask them to send the request electronically. If you use a "mail-in" pharmacy, we request you provide a completed fax form for us to send. Please call your pharmacy to check if the process has been completed. If you decide to change pharmacies after we already sent prescription through, we ask that you call the pharmacy you wish to switch to and they will call the pharmacy and have it transferred to them.

Telephone Call Policy Every phone call is important to us, and we will attempt to answer your calls and return your phone messages as promptly as possible. If it is a life threatening situation, please hang up and call 911 or go to your local emergency room. If your call is a true urgent matter, we will make every effort to respond immediately. Please allow 24 hours for non-urgent calls. If non-urgent calls are received after 4 pm, they will be returned the next business day. Please be aware that the providers will not leave their scheduled patients to return routine phone calls; these are generally answered after patient care sessions are finished. Good medical care cannot always be accomplished over the phone, so we may advise you to schedule an office visit to discuss your concerns, problems, or test results. We do encourage you to leave a detailed message, spelling your name, as we check our voicemail frequently throughout the day.

Laboratory and Other Ancillary Service Although Active Family Healthcare provides many services in the office, at times it is necessary to obtain services from an outside laboratory or other ancillary service. You will receive a separate statement of charges for services provided outside our office. An example of these services would include: Pathology Associate Medical Lab (PAML), Health Diagnostic Lab, Special specimen evaluation labs, and Radiology Services. Any questions with your statement from them, we ask that you contact them to address any issues. We don't keep track of their prices as they are always fluctuating.

Services Provided to Minors

During your absence, your child may suffer an illness or injury that requires medical attention. To ensure that your child will get the necessary attention as timely as possible, you should complete a Consent to Treatment of a Minor form. This form gives Active Family Healthcare permission to treat your child if the need arises. If we do not have this on file, we would need verbal permission that is witnessed by 2 people for us to treat without an appropriate guardian present.

As a courtesy of others and AFH, please no unattended children, talking on cell phones, and Guns in our office.

Thank you for reviewing this information carefully and for your cooperation. We look forward to meeting your medical needs.

Sincerely,

Active Family Healthcare
8836 N Hess Street Ste #E
Hayden Idaho 83835
208 758-0560