IDAHO DIABETES

# REGISTRATION FORM

(Please Print)

| PATIENT INFORMATION | | | |
|---|---|---|---|
| Today's Date: | | Referring Provider/PCP: | |
| ☐ Mr. ☐ Mrs. ☐ Ms. | Last Name: | First Name: | Middle Name: |
| DOB: | Sex: | SSN: | |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | | | |
| Home Address: | | | |
| Home Phone: | Cell Phone: | Work Phone: | |
| Email: | Employer: | Occupation: | |
| Pharmacy: | Pharmacy Phone: | Pharmacy Address: | |
| Race: | Ethnicity: ☐ Hispanic or Latino<br>☐ Non-Hispanic or Non-Latino<br>☐ Other:_____ | Language: | |

| INSURANCE INFORMATION | | | |
|---|---|---|---|
| Is this person covered by insurance? : ☐ Yes ☐ No | | | |
| Person Responsible for Bill: | Address: | Phone Number: | |
| Employer: | Employer Address: | Employer Phone: | |
| Name of Primary Insurance: | Group #: | Policy #: | |
| Subscriber's Name: | Subscriber's SSN: | Subscriber's DOB: | Co-pay/Deductible: |
| Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____ | | | |

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Emergency Contact: | Relationship to patient: | Primary phone: | Secondary phone: |
| Emergency Contact: | Relationship to patient: | Primary phone: | Secondary phone: |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the insurance company to release any information required to process my claims. I also acknowledge that there is a copy fee when asking for a copy of my medical records. I also give my permission to the staff of Idaho Diabetes and Endocrine Assoc. to download any electronic prescription that may help in my medical treatment.

_____ _____

*Patient/Guardian Signature* *Date*

13909 W. Wainwright Drive, Boise, ID 83713
208-389-2213
www.idahodiabetes.com

IDAHO DIABETES

# INITIAL MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

Age: _____ Height: _____FT _____IN Weight: _____LBS

| Do you now have or have you ever had: | No | Yes | Date | Do you now have or have you ever had: | No | Yes | Date |
|---|---|---|---|---|---|---|---|
| Rheumatic Fever | | | | Any eye disease, injury, or impairment | | | |
| Heart Disease | | | | Any ear disease, injury, or impairment | | | |
| Heart Murmur | | | | Any trouble with nose, sinuses, mouth/throat | | | |
| Shortness of Breath | | | | Any head injury | | | |
| Swelling of hands, feet, or ankles | | | | Dizziness, fainting spells, or convulsions | | | |
| Pneumonia | | | | Frequent or severe headaches | | | |
| Kidney Disease/Infections | | | | Thyroid Disease | | | |
| Sexually Transmitted Disease | | | | Skin Disease | | | |
| Bladder Infection | | | | Chronic or frequent cough, spitting up blood | | | |
| Anemia | | | | Chest Pain | | | |
| Jaundice | | | | Night Sweats | | | |
| Gallbladder Disease | | | | Varicose Veins | | | |
| Liver Disease or Hepatitis | | | | Indigestion, stomach trouble, or ulcer | | | |
| Blood Clots | | | | Rectal bleeding, severe constipation/diarrhea | | | |
| Fractures/Injuries | | | | Loss of urine with cough, sneeze, or strain | | | |
| Diabetes | | | | Autoimmune Disorder | | | |
| Take insulin for diabetes | | | | Difficulties with sex | | | |
| Epilepsy | | | | Problems with substance abuse | | | |
| Anxiety | | | | Vasectomy | | | |
| Depression | | | | Abnormal Vaginal Bleeding | | | |
| Migraine Headaches | | | | Infertility | | | |
| Cancer | | | | Breast Disease | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| High Blood Pressure | | | | Hysterectomy | | | |
| Colonoscopy/Endoscopy | | | | Ovaries removed | | | |

| **Habit**: | **Past Only** | **Never** | **Moderately** | **Daily** | |
|---|---|---|---|---|---|
| Exercise | | | | | |
| Alcoholic Beverages | | | | | |
| Cigarettes | | | | | # Packs per day:_____ |
| Smokeless Tobacco | | | | | |
| Vaping | | | | | |

| **SURGICAL HISTORY:** | | | |
|---|---|---|---|
| What | When | Where | Complications |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **DRUG ALLERGIES:** | | |
|---|---|---|
| **MEDICATION HISTORY:** | | |
| Past Medication | Dosage | Reaction |
| | | |
| | | |
| | | |
| | | |
| | | |

| **CURRENT MEDICATIONS:** | **DOSAGE:** |
|---|---|
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| **FAMILY HISTORY:** | | | |
|---|---|---|---|
| Relation | Living/Deceased | Age | Disease |
| Father | | | |
| Mother | | | |
| Sibling | | | |
| | | | |
| | | | |
| | | | |
| Husband | | | |
| Children | | | |

| **OB HISTORY:** | | | | | |
|---|---|---|---|---|---|
| Please list all pregnancies including miscarriages | | | | | |
| Year | Child's Weight | Sex | Hours of Labor | Anesthesia | Complications |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| **MENSTRUAL HISTORY:** | | |
|---|---|---|
| Age at first period: _____ | Regular: □ yes □ no | How many days is your typical cycle? _____ |
| Is your flow: □ light □ moderate □heavy | | Pain/Cramping: □ yes □ no |
| Date of last period: _____ | | Date of last PAP smear: _____ |
| Abnormal Pap Smear: □ yes □ no | Treatment for abnormal Pap Smear: □ yes □ no | Date and procedure: |
| Date of last mammogram: _____ | | Date of recent DEXA scan: _____ |

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## CONSENT FOR RELEASE OF MEDICAL INFORMATION

**I give permission for Idaho Diabetes and Endocrine Associates to provide any information about my medical condition, medical needs, medications or the status of my account to the following individual(s):**

Name of Designated Person: _____
Relationship: _____ Phone Number: _____

Name of Designated Person: _____
Relationship: _____ Phone Number: _____

Name of Designated Person: _____
Relationship: _____ Phone Number: _____

☐ PATIENT DECLINED

Patient's Signature: _____ Date: _____

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## CONFIDENTIAL COMMUNICATION REQUEST

**From time to time, it is necessary to contact you by telephone for appointment reminders, test results or other information. Often our patients are not available when we attempt to contact them and we would like to leave detailed phone messages. In order to protect your privacy we need your written permission to leave detailed phone messages on your answering machine or voice mail system.**

**Please choose one of the following:**

☐ **I DO CONSENT** for Idaho Diabetes and Endocrine Assoc. to leave detailed messages on the home or cell number I have provided.

- ☐ Home
- ☐ Cell

☐ **I DO NOT CONSENT** to leave detailed messages on my home or cell number.

☐ **REVOCATION OF PRIOR CONSENT.** I wish to rescind or stop the above authorization on this date _____.

Patient initials _____

IDAHO DIABETES

## INSURANCE BENEFITS

Dear Patients,

In an effort to make the check-out process as smooth as possible, we request that you are aware of your insurance benefits before your appointment. Although we bill your insurance company, we require payment in full for your portion of service (including co-pay and deductible). To help us collect your proper payment amount, please complete the questions below.

**Please note**: If we do not contract with your insurance, you will be asked to pay the office visit and labs in full at the time of the visit.

Insurance name: _____ Date of phone call: _____

How much is your co-pay? $_____

How much is your deductible? $_____

Has it been paid/met yet? ☐ yes ☐ no If not, how much has been met? $_____

After my deductible has been met, what percent am I responsible for? _____

Will my lab tests be covered under my co-pay or my deductible? _____

Patient signature: _____ Date: _____

**Important:** All of the above questions must be answered. If you are unaware of your benefits at the time of service (i.e., making sure our providers are in-network), you will either be asked to call your insurance company at that time or reschedule. Thank you for your cooperation and understanding.

IDAHO DIABETES

# PATIENT FEES

Dear Patients,

We will bill your insurance as a courtesy but please check with your insurance provider before your first appointment to determine your current benefits and if our providers are in-network with your plan. It is our office policy to **collect all co-payments and deductibles at the time of service.** It is very important that you know if you have met your deductible, what your co-pay is, how much has been met towards your deductible, how your insurance pays once your deductible has been met and how your insurance will process lab fees.

Also, in order to respect all patients, our fee for missing appointments (no shows) and for appointments cancelled outside the required 24 hour time frame is $75.00. As before, in case of a true emergency, we are happy to waive the fee.

Thank you for this opportunity to provide care with the utmost respect. If you have any questions regarding billing issues, please call our office and talk to the billing manager.

Sincerely,
The Staff at Idaho Diabetes and Endocrine Associates, P.A.

**I have read and understand that I am responsible for the patient portion of office visits, appropriate lab work, and/or other services and any no show fees. I understand that if my insurance does not cover any services rendered, I am responsible for any remaining balance.**

Patient printed name: _____

Patient signature: _____

Date: _____

IDAHO DIABETES

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgment)

Date: _____

Patient Name: _____ Date of birth: _____

Patient Signature: _____

I hereby acknowledge that I have receive a copy of the Idaho Diabetes and Endocrine Associates, P.A. Notice of Privacy Practices on this date or on a previous date: _____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited signature from being obtained

_____ An emergency situation prevented us from obtaining acknowledgment

_____ Other: (please specify) _____

IDAHO DIABETES

## Medical Service Arbitration Agreement

Idaho Diabetes and Endocrine Associates, P.A., a medical corporation agrees to provide to the undersigned patient medical and related health care services in consideration for payments of a fee for service basis, fees as charged by Idaho Diabetes and Endocrine Associates, P.A.

**Article I**

It is understood that any dispute as to medical malpractice that is as to whether any medical services rendered under this contract were unnecessary or unauthorized, or were improperly, negligently or incompetently rendered will be determined by the American Arbitration Association, as provide by Idaho law, and not by a lawsuit or resort to court proceedings, except as Idaho law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration as the sole means of dispute resolution.

**Article II**

Said agreement for arbitration, as provided in Article I of the agreement, shall apply to the owners, agents, representatives and employees, successors in interest and staff physicians of Idaho Diabetes and Endocrine Associates, P.A. and to the patient whether or not a minor, his heirs at law, personal representatives and any claim in tort, contract or equity. Within 30 days after any of the parties give notice to the other of demand for arbitration of any controversy, the parties to the controversy shall give notice to the American Arbitration Association then in effect. All notices or other papers required to be served shall by served by U.S. mail, registered or certified, return receipt requested.

**Article III**

Idaho Diabetes and Endocrine Associates, P.A., and its employees and agents, agree to provide such medical service as in the opinion of its Medical Care Providers are reasonable necessary and appropriate notwithstanding the opinion of any third party payer. Should the patient, for reasons personal to himself, refuse to accept the procedures, medications, or course of treatment recommended by its physicians and if the MD believed that no professionally acceptable alternative exists, and if after being so advised the patient still refuses to follow the recommended course of treatment, then the patient shall be give no further treatment and neither Idaho Diabetes and Endocrine Associates, P.A., not is medical employees and agents, shall have any further responsibility to provide services for the condition under treatment after notice of same is given to the patient.

**Article IV**

A written agreement to submit any existing controversy to arbitration or a provision in a written contact to submit to arbitration any controversy thereafter arising between the parties is valid, enforceable and irrevocable, save upon such grounds as exist at law or in equity for the revocation of any contract. This act does not apply to arbitration agreements between employers and employees or between their respective representatives (unless other provided in the agreement).

**Notice: By signing this contract, you are agreeing to have any issue of medical malpractice decided by a neutral arbitration and you are giving up your right to a jury or court trial. See Article I of this contract.**

_____ _____

Patient Name Date

_____

Patient Signature

_____ _____

Parent/Guardian/Spouse/Next of Kin Date

_____ _____

Witness Date