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 ☐ Non-Hispanic or Non-Latino ☐ 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*

9196 W Emerald Street, Suite 160
Boise, Idaho 83704
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:**

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: _____

IDAHO DIABETES

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: _____

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, you will either be asked to call your insurance company at that time or pay in full. 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.

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. 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

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 review it carefully.

YOUR RIGHTS	
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.	
Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. • We may say "no" to your request but we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, your home, your office or by phone) or to send mail to a different address • We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations • We are not required to agree to your request and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us. • You can file a complaint with the U>S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting

	www.hhs.gov/ocr/privacy/hipaa/complaints/ • We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do and we will follow your instructions.

In these cases you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation. • Contact you for fundraising efforts. *If you are not able to tell us your preference for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you.	*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	*Example: We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services.	*Example: We share information about you with your health plan to coordinate payment for your medical work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration.	*Example: Your company contracts with us to provide a health plan and we provide your company with certain statistics to explain the premiums we charge.*

OTHER USES

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information

see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html	

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  ○ Preventing disease
	  ○ Helping with product recalls
	  ○ Reporting adverse reactions to medications
	  ○ Reporting suspected abuse, neglect, or domestic violence
	  ○ Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  ○ For workers' compensation claims
	  ○ For law enforcement purposes or with a law enforcement official
	  ○ With health oversight agencies for activities authorized by law
	  ○ For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of This Notice

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we can mail a copy to you upon request.

This Notice of Privacy Practices applies to the following organization.

Idaho Diabetes and Endocrine Associates
9196 W. Emerald St, Ste 160
Boise, ID 83704

This notice was revised on: 11/2/2016

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR NEED MORE INFORMATION,
PLEASE CONTACT OUR PRIVACY OFFICER:

Theodore S. Roosevelt, M.D.
9196 W. Emerald St, Ste 160
Boise, ID 83704
Phone: (208) 389 -2213
Fax: (208) 389-4659

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

IDAHO DIABETES

PRESCRIPTION REFILL POLICY

There are many legal, medical, and ethical issues we must consider and follow when authorizing a continuation of a medication prescription. We have strict policies to protect both you and our providers. Our staff has been directed to follow these policies for your safety. Please do not ask our staff to make exceptions for you.

1. We will only refill medications prescribed by Idaho Diabetes and Endocrine Associates. We will not authorize refills for medications prescribed by another provider. If you have requested that we take over management of these medications, we will be able to continue your prescription for you.
2. We may not refill a prescription if you have not had an appointment within the last three months or if you missed your previously scheduled appointment. We must be able to monitor your progress and response to medication on a regular basis to determine if the dose is appropriate.
3. No refills may be authorized by the staff beyond the follow up appointment date noted by your provider in the progress note. If you have not been seen by the recommended follow up date, the provider may authorize up to a one month supply. This is to give you time to schedule an appointment with our office or transfer care to another provider.
4. It is important to report all medications that you are taking to every provider you are seeing, to avoid potential drug interactions. Carrying a medication list with you is a good idea. You can pick up a medication card from our front desk. Please bring this card to every visit.
5. It is your responsibility to notify your pharmacy that you are in need of a refill prior to running out. The pharmacy will then send our office a notification of your request. Please allow two (2) business days for your request to be processed.