PLEASE SHOW INSURANCE CARD TO RECEPTIONIST

Payment or co-pay is due at time services are rendered

PATIENT	**GUARANTOR** (Person Responsible for Account)
Last Name:	**If same as: (Circle one) Patient Spouse and information is already completed, you do not need to complete below**
First Name:	
Middle Name:	Last Name:
Social Security #:	First Name:
Birth Date:	Social Security #:
Birthplace:	Birth Date:
Gender: Male Female	Birthplace:
Language: English Spanish Other **Race:** White/Black or African American/American Indian/Hispanic/ Other/Declined to answer **Ethnicity**: Are you Hispanic or Latino? Yes No	Marital Status (circle): Sgl Married Divorced Separated Life Partner Widowed
Advanced Directive : Yes No **Marital Status** (circle): Sgl Married Divorced Separated Life Partner Widowed	Mailing Address:
Mailing Address: City: State: Zip:	City: State: Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Email:	E-mail:
Employer	Employer
Employer Addr/Phone:	Employer Addr/Phone:
	Occupation
Occupation	
Pharmacy:	
Primary Insurance:	
Name on Card:	
Cardholder's Birth Date:	
ID#	
Group #	
Secondary Insurance:	
Name on Card:	
Cardholder's Birth Date:	
ID#	
Group #	
Spouse Name:	
Address: Same as patient ☐	
Social Security #:	
Birth Date:	
Birthplace:	
Cell Phone:	
E-mail:	
Employer:	
Employer Address/Phone #	
Occupation	
Emergency Contact Name:	
Address/Phone:	
Relationship:	

Bear Lake Orthopeadic

Name_____ Date of Birth____/____/____

Today's Date _____ What are we seeing you for today?_____

How did it happen? _____

Date of injury _____ X-rays taken? **YES / NO** Prior treatment? **YES / NO**

Primary Care Physician _____ Referring Physician_____

Drug Allergies _____

Current Medications/dosage _____

_____

Hospitalizations/Surgeries_____

_____

Review of Symptoms

Please circle if you are now experiencing any of the following:

Fever/Chills	Vomiting	Diarrhea	Constipation
Night Sweats	Bladder incontinence	Blood in stool	Numbness/Tingling
Palpitations	Abdominal pain	Chest pain	Joint pain
Wheezing	Bowel incontinence	Headaches	Shortness of breath

Other:_____

Lifestyle

Occupation:	Alcohol use: **Yes / No** **If yes, amount per day**_____	Tobacco use: Smoke / Chew **Quanity per day**_____
Exercise: o Less than 1 time per week o 1 to 3 times per week o 4-7 times per week o daily	Type of exercise: o Running o Biking o Aerobic o Weight training o Other_____	Diet: o Fairly balanced o Eat too much o Lots of fast food o I follow a diet program
Second hand smoke **Yes / No**	Recreational Drug use: **Yes / No**	Addiction Help: **Do you need a doctor's help with drug addiction?** **Yes / No**

Name -_____

Please circle if you have a medical history of the following:

Anemia	Anesthetic problems	Arthritis	Asthma
Blood clots	Cancer/ what kind?_____		Infections
Gout	Digestive disorder	Acid reflux	Ulcers
Ulcerative colitis	Depression	Heart disease	Hepatitis
Heart problems	Heart surgery/what kind?_____		Pneumonia
Heart attack/how many?_____	When?_____	High blood pressure	Diabetes
Kidney disease	Osteoporosis	Stroke	Epilepsy
Latex allergy	Tuberculosis	Mental illness/attempted suicide	
Thyroid disease			

Women

Pregnant	Planning Pregnancy	Nursing

Family History

Please check circle if you have a family history of the following:

Heart Disease?	High Blood Pressure?	Cancer?	Arthritis?
o None	o None	o None	o None
o Father	o Father	o Father	o Father
o Mother	o Mother	o Mother	o Mother
o Mother's Father	o Mother's Father	o Mother's Father	o Mother's Father
o Mother's Mother	o Mother's Mother	o Mother's Mother	o Mother's Mother
o Father's Father	o Father's Father	o Father's Father	o Father's Father
o Father's Mother	o Father's Mother	o Father's Mother	o Father's Mother
o Brother	o Brother	o Brother	o Brother
o Sister	o Sister	o Sister	o Sister
o Child	o Child	o Child	o Child

Diabetes?	Bleeding Problems?	Osteoporosis?	Other?
o None	o None	o None	
o Father	o Father	o Father	_____
o Mother	o Mother	o Mother	_____
o Mother's Father	o Mother's Father	o Mother's Father	_____
o Mother's Mother	o Mother's Mother	o Mother's Mother	_____
o Father's Father	o Father's Father	o Father's Father	_____
o Father's Mother	o Father's Mother	o Father's Mother	_____
o Brother	o Brother	o Brother	
o Sister	o Sister	o Sister	
o Child	o Child	o Child	

CONSENT TO TREAT

I consent to and authorize Bear Lake Orthopeadic clinic to furnish me, and/or my dependents, with necessary medical care. This medical care may include radiology examination, laboratory testing and other diagnostic procedures as may be required.

RELEASE OF MEDICAL INFORMATION

I consent to and authorize Bear Lake Orthopeadic clinic to disclose all or part of my, or my dependents, medical records to my mutually agreed upon referring physicians.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I consent to and authorize Bear Lake Orthopeadic clinic to furnish medical information to any third party who may be responsible for payment of all or part of any charges incurred in this office.

I authorize my insurance company, or any responsible third party to pay benefits directly to the Bear Lake Orthopeadic clinic.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for the payment of medical charges incurred on my or my dependent's behalf at the office of Bear Lake Orthopeadic clinic, regardless of third party coverage.

_____ _____

Patient signature/Guardian **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I certify that I(or my Guardian) have received at copy of the Notice of Privacy Practices on behalf of Dr. K.G. Jepsen, M.D.,dba Bear Lake Orthopeadic clinic

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_____ _____

Patient signature/Guardian **Date**

MEDICARE AUTHORIZATION (if applicable)

I request that payment of authorized Medicare benefits be made on my behalf to Bear Lake Orthopeadic clinic. I authorize the holder of my medical information to release to the Health Care Financing Administration and its agents any information required to determine those benefits.

_____ _____

Patient signature **Date**

NOTICE OF PRIVACY PRACTICES RECORD OF ACKNOWLEDGMENT

Name of Patient: _____ **Date:** _____

We are committed to preserving the privacy and confidentiality of your health information whether created by us or maintained on our premises. We are required by certain state and federal regulations to implement policies and procedures to safeguard the privacy of your health information. We are required by state and federal regulations to abide by the privacy practices described in the notice provided to you including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is April 14, 2003.

Changes or Revisions to Our Privacy Notice

We reserve the right to change our *Privacy Notice* at any time and to make the revised or changed notice retroactive and effective for health information we already have about you as well as any information we receive in the future about you. Should we revise or change our *Privacy Notice*, we will post a copy of the new or revised notice in our main lobby. You may obtain a copy of the new/revised *Privacy Notice* from the HIM/Medical Records Department, Admissions Office or download a copy from our website.

☑ Our Privacy Notice was revised on July 13, 2013. ☐ No changes since the effective date listed above.

Privacy Notices, Information Restrictions, Record Amendments/Corrections, Disclosures of Information, Revoking an Authorization, Inspection and Copying of Records, Confidential Communications, Filing Complaints, Etc.

Should you have any questions concerning our privacy practices, obtaining copies of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your health information, obtaining a listing of the information we disclosed concerning your health information, requests to inspect or copy your medical information, requests that we communicate information about your health matters in a certain way, denial of access to your health information, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

Provider/Privacy Contact Information:
Bear Lake Memorial Hospital

Attn: Privacy Officer and/or HIM/Medical Records Dept.
164 South 5th Street
Montpelier, ID 83254
(208) 847-1630

You may also file complaints with:
U.S. Secretary of the Dept. of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201
(202) 619-0257
Toll-Free 1-877-696-6775

Acknowledgment

I certify that I accepted_____ or declined_____ a copy of the provider's *Privacy Notice* and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting my health information.

Date:	Signature of Patient:	Printed Name of Patient:
Date:	Signature of Witness:	

I certify that I am the authorized representative of _____, and that I have received the *Privacy Notice* on behalf of this individual and that the provider provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the provider is committed to protecting health information.

Date:	Signature of Representative:	Printed Name of Representative:	Relationship to Patient:
Date:	Signature of Witness:		

A copy of this document must be provided to the person to whom the *Privacy Notice* was provided and a copy must be filed/scanned in the HIM/Medical Record's Department.