Borron FAMILY MEDICINE

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Phone: 208-639-3990 Fax: 208-639-3992

REGISTRATION FORM

(Please Print)

Today's Date:			PCP:	
Patient's Last Name	First	Middle	☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital Status (Circle) Single/Mar/Div/Sep/Wid
Is this your legal name? ☐Yes ☐No	If no, what is your legal name?		Former name (if applicable)	
E-mail Address			Birth Date / /	Age / Sex ☐M ☐F
Street address	Social Security No.		Home Phone ( ) Cell Phone ( )	
PO Box	City		State	Zip
Occupation	Employer		Employer Phone ( )	
Chose clinic because/referred to clinic by: (check one box)	☐Dr.		☐Insurance Plan	☐Hospital
☐Family ☐Friend ☐Close to home/work ☐Yellow Pages ☐Other				
Other family members seen here:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill	Birth Date / /	Address (if different)			Home phone ( )
Is this person a patient here? ☐Yes ☐No					
Occupation	Employer		Employer Phone ( )		
Is this patient covered by insurance? ☐Yes ☐No					
Please indicate primary insurance	☐Blue Cross	☐Blue Shield	☐Aetna	☐United	☐Pacific Source
	☐Other				
Subscriber's Name	Subscriber's SS No.	Birth Date / /	Group No.	Policy No.	Co-payment $
Patient's Relationship to subscriber	☐Self	☐Spouse	☐Child	☐Other	
Name of secondary insurance (If applicable)	Subscriber's name:		Group No.	Policy No.	
Patient's Relationship to subscriber	☐Self	☐Spouse	☐Child	☐Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address)	Relationship to patient	Home Phone ( )	Work Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Borron Family Medicine or insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____

Borron Family Medicine New Pediatric Patient

Child's Name:_____ Birth Date:_____

NEW MEDICATIONS: Please list the child's dose and frequency of chronic medications.

_____

ALLERGIES: Please list any drug and/or food allergies, reaction if ingested, and date first noted.

_____

SURGERY: Please list any new surgeries and dates.

_____

HOSPITALIZATION: Please list any new hospitalizations and dates.

_____

Social History

Parent's Name: _____Marital Status: _____Parent's Occupation:_____

Parent's Name: _____Marital Status: _____Parent's Occupation:_____

Legal Guardian, if other than parents:_____

Do you have other children? Yes _No If Yes, how many? _____What are their ages?

_____

Who lives in the household?_____

_____

Are there any pets in the home? If yes, what kind?_____

Does anyone in the household smoke?

_____

If yes, outside or inside?_____

Are there any guns in the home? _____

If yes, are they locked?_____

Are your child's parents married? If not, what is the custody arrangement?_____

Lead risk: What year was your home/apartment built?_____

TB risk: Has the child traveled or lived outside of the U.S. for longer than 2 weeks? If so, what country?_____

Is your child in daycare? If so, what kind (in-home, group, babysitter, nanny)?_____

School

Current School/ Daycare_____

If daycare how often?_____

Grade Level_____

Any concerns about school performance?
o NONE o Yes
If yes, explain_____

Nutrition

Was your child breast fed? o Yes o NoIf yes, for how long?_____

Has your child had any unusual dietary/ feeding problems? o No o Yes If yes, please specify:_____
_____

Sleep

Hours per Night _____

Naps (number & length) _____

Where does your child sleep?
_____

Any sleep problems?
_____

Dental History

Has your child been seen by a dentist? o Yes o No

Languages spoken at home?_____

Does your child visit the dentist every 6 months?_____

Dentist:_____
_____

How often?
_____

Dental Problems? Explain
_____

Braces o Yes o No

Orthodontist:_____

Concerns about your child?

o Alcohol use o Smoking o Substance abuse o Sexual activity o Peers

If yes, explain_____

Activities/Exposures/Habits

Activities: o Sports
_____
_____

o Music_____

o Scouts_____
oClubs/Groups_____
oOther_____

How Often?
_____

Exercise, how often?_____

Screen time (TV, computers, video games)_____hrs/day

Pediatric Review of Systems

Please check any current problems your child has on this list

General
o Fever o chills o excessive sweating
o Fatigue
oUnexplained weight loss o Unexplained weight gain

Eyes
o" Crossed "eyes o lazy eyes o Wears glasses ocontacts

Ears/ Nose/Throat
o Frequent ear infections o Hearing loss
o Snoring
o Frequent sore throats o Frequent bloody noses
o Frequent runny nose o Problems with teeth and gums

Respiratory
o Chronic Cough o Wheeze o Chest pain
o Recurrent Croup
o Shortness of breath with exercise

Cardiovascular
o Heart Murmur o Fainting
o Poor endurance compared to peers

Gastrointestinal
o Nausea oUnexplained Vomiting oChronic

Diarrhea
oChronic Constipation
o Frequent stomach aches
o Blood in stools o Soiling underwear
o Jaundice

Genitourinary
o Bed wetting o Daytime wetting o Pain with urination
o Blood in urine o frequent urination
o Painful periods o Irregular periods

Musculoskeletal
o Joint pain oJoint swelling o Muscle weakness

Skin
o Unusual moles o Rashes o Hives o Acne o Bruising

Neurologic
oMigraine Headaches oTension Headaches
o Weakness
o Dizziness o Fainting o Seizures o Starring spells
o Memory problems

Psychiatric/Emotional /Education
o Anxiety/stress o Depression
o Aggression/fighting
o Defiant o Fearful o Nail biting o Thumb sucking
oSleep difficulty o Speech problems
o Learning difficulty
o Special Ed

Nutrition
o Overweight o Underweight o Obesity
o Anorexia
OtherConcerns_____
_____
_____

FINANCIAL POLICY

We appreciate the opportunity to provide health care services to you and your family.

Please read and initial **ALL** the following:

_____**PAYMENT POLICY:** Payment is due at the time of service. Patient or guarantor is required to pay for all co-pays, deductibles, and out-of-pocket expenses. We accept Visa, Mastercard, personal imprinted checks, and cash. In the event that a check is returned, a $25 service charge will be assessed. Any unpaid balance must be paid prior to being seen by the doctor or having a prescription refilled. If an account is not paid in full within 90 days, the account will be sent to collections which may result in being discharged as a patient from this office.

_____**PAYMENT ARRANGEMENTS:** Payment arrangements will be issued on a case by case basis only. Short-term arrangements may be granted but will require a signed authorization to automatically deduct payments from a credit card and must be paid in full within 90 days.

_____**INSURANCE:** We participate and are contracted with many local insurance companies. We do recommend that you contact your insurance company to ensure that your policy does not limit your choice of providers prior to your visit. We will bill your insurance for all charges that incur. You will ultimately be responsible for any charges that your insurance company does not cover. Any unpaid balance over 90 days will be assessed a 1% interest.

_____**MINOR PATIENTS:** Any patient under 18 years of age scheduled for a non-emergency treatment may be denied without a parent/guardian present or without prior consent. Emergency treatment, however, will not be denied. A parent/guardian who schedules an appointment for an unaccompanied minor is considered to be authorizing care for that visit, and will therefore be liable for any charges for that appointment.

_____**NO SHOW/CANCELLATION POLICY:** It is required that a 24 hour notice be given to cancel any scheduled appointments. If a 24-hour notice is not given, we will bill a $25 fee.

I have read and understand this Financial Policy. I consent to, and authorize the health care providers at Borron Family Medicine to furnish me with necessary medical care. This medical care may include radiology examinations, laboratory testing and other diagnostic procedures that may be required. I will adhere to the above guidelines and will have any questions answered before signing.

Signature of Responsible Party: _____

Printed Patient Name: _____

Date: _____

Borron Family Medicine

Authorization for Treatment and/or Immunization of Minors

In the absence of parents or guardians

Today's Date:_____

Patients' Name: _____Date of Birth_____

I hereby authorize treatment of the above child and give permission for treatment during my child's preventive medical examination or sick examination. This form remains in full effect until rescinded in writting by parent/legal guardian.
The following person(s) listed below are authorized to bring my child:
Name: Relationship:

_____

_____

_____

* All persons selected to bring your child to our office must be 18 years of age or older and required to show a current photo ID.

Borron Family Medicine follows the recommended immunization schedule of the American Academy of Pediatrics. I give permission for the administration of the recommended vaccines._____(initial)

OR

I hereby request no immunizations be given to my child at their examination____(initial)

Parent/Legal Guardian Signature: _____
Parent/Legal Guardian Printed Name:_____

* My child is 16 years of age (or older) and has a current driver's license. I give Borron Family Medicine authorization to treat my child for; preventive medical examination, vaccine administration, and/or sick visits.
If a provider needs to call me while my child is being seen you can contact me at:( )
_____.

This form remains in full effect until rescinded in writting by parent/legal guardian.
Parent/Legal Guardian Signature: _____
Parent/Legal Guardian Printed Name:_____

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AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Patient Name:_____ Date of Birth:_____

Address:_____

Former name (if applicable):_____

Release information **from** :_____

Address/Phone/Fax :_____

_____

Release information **to**:_____

Address/Phone/Fax:_____

_____

Purpose of Release:

Insurance ____	Personal _____	Treatment/Continuation of care ____	Legal _____	Other _____

Information to be released (specify all):

Clinic Notes ____	Lab/Pathology ____	Imaging reports ____	Mental Health ____
HIV/AIDS/STD ____	Substance Abuse ____	Behavioral Health____	Other (specify)_____
Progress Notes ____	History Physical ____	Immunizations ____	Procedure reports ____

The person (s) listed above may use or disclose information relating to the patient's care during the following:
From _____ to _____
I understand that I have the right to revoke this authorization at anytime except to the extent that action has been taken in reliance on this authorization. To revoke this authorization I must submit a written revocation to Borron Family Medicine.
I understand that my health care cannot be conditioned on this authorization unless:
1. the purpose for evaluation and treatment is to obtain and disclose information to entities consistent with this authorization.
2. the patient is involved in research-related treatment and the use of disclosure is for such research.
I understand that information disclosed by Borron Family Medicine's pursuant to this authorization may be re-disclosed by the entity that receives the information and may no longer be protected by privacy regulations.
I understand the information to be released may include records related to behavioral and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
If information is disclosed for records protected by Federal confidentiality rules, the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted in writing, by the person to whom it pertains or as otherwise permitted.
This authorization will expire on the following date: _____
If no specific date is given this authorization will expire on (1) year from the date of this authorization.

_____ _____

Signature Date

_____

Relationship to Patient

Borron Family Medicine Statement of HIPPA Compliance
June 1st 2013

HIPAA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996, Public Law 104-191. This law was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data. It will also protect the privacy, confidentiality and security of health care information. It affects all areas of the health care industry.

Borron Family Medicine has a long-standing history of supporting and participating in supporting standards programs for more than 3 years. Borron Family Medicine upholds the HIPAA objectives and is proactively enhancing our existing HIPAA-compliance initiatives. Borron Family Medicine has committed to track and provide coordination, education, and communication for all HIPAA activities company-wide. This is for monitoring and verifying that all HIPAA efforts for readiness are proceeding successfully within Borron Family Medicine responsible organizations.

The complete text of the proposed and finalized rules, along with comments, is available at: http://aspe.hhs.gov/admnsimp.

If you have any further questions regarding Borron Family Medicine processes or HIPAA-readiness issues, please ask your HIPPA question through an e-mail addressed to info@borronfamilymedicine.com When making your inquiry, please mention that you are requesting additional information.

Patient Health Information (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing, and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or healthcare operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care provider or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations the DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, disease, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health or others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level that are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative o any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.
In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies. You have the right to obtain an electronic version of your PHI upon request. There may be a charge to receive an electronic copy of your PHI.
If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the exiting information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.
You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.
Your PHI will not be used for the purpose of raising funds. Occasionally our organization uses testimonials from patients to promote our business and expertise. Only after obtaining written authorization from you will your PHI be used for this purpose.
Uses and disclosures not described in this Privacy Notice will be made only with your prior written authorization.

Our Legal Duty

If there is an un-intended breech in the security of the PHI we will attempt to notify you of the breech. We will perform a risk assessment and notify you of the results. We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.borronfamilymedicine.com. You can also request a copy of our Notice at any time.
If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Compliance Officer listed below. You may also send a written complaint to the US Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:
Borron Family Medicine
Attn: Brookney Borron Compliance Officer
790 W Ustick Rd Suite 110
Meridian, ID 83646 208-639-3990
Brookney@borronfamilymedicine.com

You may also go to the health and human services web site to file a complaint
http://www.hhs.gov/ocr/privacy/hippa/complaints/

I understand that a patient's health information is private and confidential. I understand that Borron Family Medicine has procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist Borron Family Medicine by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

_____

Patient's Signature
Effective June 1st 2013