Brookney Borron FNP-C
Christie Beattie FNP-C

790 W. Ustick Rd., Suite 110 Meridian, ID 83646
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:______________

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PATIENT DATA BASE

DATE: ____________________

NAME: ______________________________ DOB: ____________ AGE: ________ SEX: ________

MARITAL STATUS: S / M EDUCATION (years completed): ______________________________

OCCUPATION: ______________ MEDICATION ALLERGIES 1. __________ 2. __________ 3. __________

CURRENT MEDICAL PROBLEMS		LIST ALL MEDICATIONS NOW TAKING (including no-prescription)	
1.	4.	1.	4.
2.	5.	2.	5.
3.	6.	3.	6.

LIST HOSPITALIZATIONS AND SURGERIES

1. ____________________ 3. ____________________ TOBACCO USE : ____________

2. ____________________ 4. ____________________ ALCOHOL USE: ____________

WHEN WAS YOUR LAST TETANUS SHOT? ______________ WHEN WAS YOUR LAST PHYSICAL EXAM? ____________

FAMILY HISTORY

FAMILY MEMBER	LIVING AGE	LIVING HEALTH	DECEASED AGE	DECEASED CAUSE
FATHER				
MOTHER				
SPOUSE				
BROTHER/SISTERS				
1.				
2.				
3.				
4.				
5.				
6.				
CHILDREN				
1.				
2.				
3.				
4.				

HAVE YOU OR ANY RELATIVES HAD:

	NO	YES	WHO
DIABETES			
THYROID			
ALLERGY/ASTHMA			
CHOLESTEROL			
HIGH BLOOD PRESSURE			
HEART TROUBLE			
STROKE			
CANCER OR TUMOR			
TUBERCULOSIS			
BLEEDING DISORDER			
EPILEPSY/CONVULSIONS			
MENTAL ILLNESS			
KIDNEY/BLADDER TROUBLE			
BIRTH DEFECTS			

OTHER ______________________________

Borron Family Medicine New Patient Preventative Medicine Questionnaire

Previous Providers of Care:

____

Recent Imaging (Including xrays, CT scans, MRI, US, colonoscopy, mammogram, DEXA, etc)

____

Date of your last Eye Exam:

____

Date of your last Dental Exam:

____

Recent Immunizations:

____

Current Diet:

____

Current Exercise:

____

Do you smoke cigarettes or cigars, or use smokeless tobacco? Yes ____ No ____

Alcohol Use: None ____ 1/day _____ More than 1/day _______________

Illicit Drug use: None ____ Occasional ____ Daily ____ Drug used _______________

How do you rate your health? Excellent ____ Good ____ Poor ____

Signed: ______________________________ (patient) Date: __________________

Reviewed: ______________________________ (Provider) Date: __________________

Borron FAMILY MEDICINE

Patient Name:________________________**DOB:**________________________

Review of Systems (Current health symptoms): Please complete all questions:

Y/N -Have you had a recent weight gain or loss that worries you?

Y/N -Have you had any unexplained fevers or night sweats?

Y/N -Do you have sinus/nasal allergy symptoms that affect your Quality of life?

Y/N -Do you have any vision or hearing problems that are bothersome?

Y/N -Are you experiencing chest pains or irregular beats that worry you?

Y/N -Do you have unusual shortness of breath or a persistent cough?

Y/N -Do you have leg swelling that is recurrent or bothersome?

Y/N -Do you experience wheezing when you breathe?

Y/N -Do you have sleep problems that interferes with quality of life?

Y/N -Have you been told that you snore and stop breathing during sleep?

Y/N -Do you have constipation, diarrhea, stomach pain or other problems with digestion that interfere with your quality of life?

Y/N -Have your bowel movement patterns changed in recent months?

Y/N -Do you have problems with urination that affects quality of life?

Y/N -Do you have problems with sexual function that affects quality of life?

Y/N -Do you have joint or back problems that affect your quality of life?

Y/N -Do you have leg pain, numbness or weakness that limits your walking?

Y/N -Do you have headaches that affect your ability to function?

Y/N -Have you had dizziness or an unexpected fall in the past year?

Y/N -Do you have poor balance or fear of falling?

Y/N -In the past 4 weeks, have you had little pleasure in doing things?

Y/N -In the past 4 weeks, have you felt down, depressed, or hopeless?

Y/N -Are you concerned about anxiety or stress in your life?

Y/N -Are you concerned about your memory?

Y/N -Have you noticed unusual bruising or bleeding?

Y/N -Do you have unusual skin lesions that concern you?

Comments:

____

Provider: ____________________**Intials:** ________ **Date Reviewed:** ____________

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: ______________________ **Date of Birth:** ______________ **Age:** __________

Gender (M/F):________ **Today's Date(MM/DD/YY):**____________ **Health Care Provider:**________________

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	—	—	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family
- ☐

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage
‡In the same individual or on the same side of the family
§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Lynch Syndrome - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome or MAP syndrome mutation in the family
- ☐

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern
***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^Cancer history should be on the same side of the family

**Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature:_______________________________ Date: __________

Health Care Provider's Signature: ___________________________ Date: __________

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐☐ YES ☐☐ NO ☐☐ ACCEPTED ☐☐ DECLINED
Follow-up appointment scheduled: ☐☐ YES ☐☐ NO Date of Next Appointment:__________

RFCFHQ/06-13

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
790 W Ustick Road Suite 110
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208-639-3990
Fax 208-639-3992

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.

Borron Family Medicine **HIPPA Policy & Privacy Practices**

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