ERIK S. JONES, DO

Board Certified Family Physician

Sarai Graves, PA-C

Certified Physician Assistant

222 N. 2ND ST, STE 311

BOISE, ID 83702

Phone: (208) 344-6080 Fax: (208) 344-6079

DPC REGISTRATION

PATIENT INFORMATION DATE: _____

FULL LEGAL NAME: _____
LAST FIRST MIDDLE

_____
PREFFERED NAME/NICKNAME

_____
STREET ADDRESS/P.O BOX

_____
CITY STATE ZIP

PREFERRED PHONE:_____ CONTACT TYPE:_____

SECONDARY PHONE:_____ CONTACT TYPE:_____

DOB:_____ SSN:_____

RACE:_____ _ LANGUAGE PREFERENCE:_____

ETHNICITY: HISPANIC:___ NON-HISPANIC:___ OPT OUT:___

PREFERRED PHARMACY:_____

CROSS STREETS:_____

PERSON TO CONTACT IN CASE OF EMERGENCY

(MUST BE SOMEONE OTHER THAN PATIENT OR RESPONSIBLE PARTY)

NAME _____ PHONE _____

YOU MUST PROVIDE PROOF OF INSURANCE AT THE TIME OF YOUR INITIAL VISIT. IF YOU DO NOT HAVE YOUR INSURANCE CARD YOU WILL BE CONSIDERED A SELF PAY PATIENT AND FULL PAYMENT WILL BE DUE AT THE TIME OF YOUR VISIT. YOU ARE ALSO RESPONSIBLE FOR PAYING ANY COPAYMENTS OR COINSURANCE DUE AT THE FRONT DESK PRIOR TO YOUR VISIT. THANK YOU

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NOTICE OF PRIVACY PRACTICES

Effective Date: January 1st 2012

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.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

- We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose information without your authorization for several reasons as required by law. But beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.

YOUR RIGHTS:

- In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information

OUR LEGAL DUTY:

- We are required by law to protect the privacy of your health information, provide this notice about your privacy practices, follow the privacy practices that are described in this notice and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in accessible public areas. You may also request a copy of our notice at any time.

PRIVACY COMPLAINTS:

- If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision, we have made about access to your health information, you may file a formal complaint in writing to us directly. You may also send a written complaint to the U.S. Department of Health and Human Services.

This is a brief description of how we handle your health information. If you wish to read an entire copy of this notice or would like an entire copy of this notice, please feel free to request one.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

- Our "*Notice of Privacy Practices"* provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

- I have been provided with the condensed version of the notice and I will be given an opportunity to review an entire copy of the notice upon request.

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AUTHORIZATION OF RELEASE OF PAYMENT

- In regard to any and **all insurance carriers** that I am contracted with including but not limited to; Medicare / Medicaid / Tri-Care / Commercial / Third Party Liability.

- I authorize that payment of all eligible **insurance benefits** be made to Dr. Erik S. Jones for any services furnished to me by the providers in Dr. Erik S. Jones' clinic.

- I authorize the release of any and all medical information about me to the **Centers for Medicare and Medicaid Services and/or any Insurance Company** that I have contracted with, and its agents for the sole purpose of determining payment of these benefits for related services.

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FINANCIAL OFFICE POLICY

PAYMENT POLICY:

- **All deductibles, co-pays and patient responsibility payments are due and payable at the time of service.** Any exceptions to this must be discussed prior to seeing the doctor.
- We accept CASH, CHECKS, DEBIT, VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER.
- Checks returned for insufficient funds are subject to a $50 service charge. If a check is returned, you will have 30 days from the date of our notification to pay the balance plus all applicable charges.

OVERDUE/EXCESSIVE BALANCES:

- **Accounts that reach over $500 without a payment** from the patient or guardian may result in the denial of appointment requests and medications refills. In these instances, we require patients or guardians to sign a Payment Agreement, that includes making regular monthly payments towards the balance. Failure to make a significant payment or to sign a Payment Agreement may result in sending the patient's account to collections.
- **Patients with balances that are over 120 days past** due without a payment from the patient or guardian may result in the denial of appointment requests and medications refills. In these instances, we require patients or guardians to sign a Payment Agreement, that includes making regular monthly payments towards the balance. Failure to make a significant payment or to sign a Payment Agreement may result in sending the patient's account to collections.

INSURANCE:

- **It is the responsibility of the patient or parent/guardian to know the benefits of your insurance plan.**
- We participate with and are contracted with many insurance companies and will bill your charges with our office to your insurance company. In order to do this accurately, we must have corrected and updated insurance information. Please notify us of any changes at each visit.
- Please be aware that some or all the services provided and billed to your insurance company may not be a covered benefit. These non-covered benefits will be billed as patient due after notification from your insurance company has been received. Refer to your insurance contract or contact your insurance customer service center if you have any questions.

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FINANCIAL OFFICE POLICY CONTINUED

MINOR PATIENTS:

- Non-emergency treatments will be denied without a parent/guardian present or without prior consent. A parent/guardian who schedules an appointment for an unaccompanied minor is authorizing care for that visit. Emergency treatment will not be withheld, however. We will make every effort to contact a responsible party.
- The responsible adult accompanying the minor will be responsible for payment at the time of service.
- We cannot be held responsible to try to collect from multiple sources (i.e. divorced parents). We will bill the responsible party at the address listed.

INTEREST:

- We reserve the right to charge interest in the amount of 1.5% per month on past due accounts as allowed by state law.

NO SHOW - CANCELLATION POLICY:

- **It is required that a 24-hour notice be given to cancel any scheduled appointment.**
- If a 24-hour notice is not given and you fail to show up for your appointment, we reserve the right to charge the patient or the responsible party **a fee of $100.00 per occurrence.**
- If you call, but it is less than 24-hour notice, or arrive too late to be seen for your appointment, we reserve the right to charge you **a fee of $50.00 per occurrence.**
- Upon a second violation of the no show-no cancellation policy, dismissal from the practice may occur.

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ANNUAL WELLNESS EXAM & LABS POLICY

Most insurance plans pay for an Annual Wellness Visit and certain screening tests without deductibles or co pays. As your health care provider, we encourage you to have one every year and want you to be aware of the specific guidelines for the wellness visit. An Annual Wellness Visit is not a comprehensive physical exam.

The Annual Wellness Visit will include:

- Updating your medical and social history, including a list of all your health care providers
- Assessing health risk factors and the presence of any medical conditions
- Blood pressure, height, weight, and BMI measurements
- Screening for conditions related to cognitive impairments, depression, and functional status.

At this visit your provider will work with you to create a personalized plan to help keep you healthy over the next few years. Subsequent Annual Wellness Visits will update the information gathered at the first visit. The Annual Wellness Visit is not a physical exam but rather a review of your health, plus education and counseling about preventive services.
To provide our patients with the most comprehensive medical care, if you have other chronic or acute medical conditions**, we may perform a physical exam and/or cover medical issues at the time of your appointment which is not considered part of the Annual Wellness Visit. If this is done, a separate office visit charge will be billed where deductibles and co pays would apply.**

Lab panels that are ordered for this exam are based on your specific needs. We cannot guarantee that your specific panel will be covered without deductible or co-pay as each insurance carrier has different guidelines. For specific lab questions please consult your insurance plan.

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MEDICATION REFILL POLICY

REQUESTING REFILLS:

- It is your responsibility to request refills from your pharmacy in a timely manner when necessary. Approval of your refill may take up to three (3) business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact the pharmacy fourteen (14) days before your medication is due to run out.
- **Medication refills will only be addressed during regular office hours** (Monday-Thursday 8am-4pm & Friday 8am-12pm). The on-call physicians will not return any phone calls regarding refills. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays so please plan accordingly.
- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

CHANGING PHARMACIES:

- If you change pharmacies, it is your responsibility to notify the office of the change. If a prescription is sent to the incorrect pharmacy due to the office not being notified in a timely manner, we will be unable to resend the prescription until the next business day.

PRIOR AUTHORIZATION FOR MEDICATIONS:

- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

APPOINTMENTS FOR REFILLS:

- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. **All prescriptions require a follow up appointment every 3 to 6 months.**

ADJUSTING MEDICATIONS:

- **If you have any questions regarding medications, please discuss these during your appointment.** If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately. New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

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IDAHO HEALTH DATA EXCHANGE
Privacy Policy

PRINT PATIENT NAME: _____

PRINT NAME OF LEGAL GUARDIAN/REPRESENTATIVE: _____

This office participates in the Idaho Health Data Exchange (IHDE). This is a secure statewide internet-based health information exchange with the goal of improving the quality and coordination of health care in Idaho. IHDE allows us to easily share your protected health information with other participating healthcare providers involved in your care.

If you do not want your information shared through IHDE, and therefore not available for coordination of care with other healthcare providers, you can opt out.

TO OPT OUT: You must complete and sign the IHDE "Request to Restrict Disclosure of Health Information" form which you can find on IHDE's website at idahohde.org.

Mail or fax the completed form to IHDE. You will receive a letter of confirmation upon completion of your request. This will restrict your information from being released through IHDE only (you will also need to directly contact any facility you wish to restrict your information from).

SIGNATURE OF PATIENT **OR** LEGAL GUARDIAN/REPRESENTATIVE DATE

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PATIENT PORTAL GUIDELINES, POLICY & PROCEDURES

DO NOT USE EMAIL TO COMMUNICATE IF THERE IS AN EMERGENCY OR TO COMMUNICATE ABOUT HIV/AIDS:

- In an emergency, call 911 or for urgent needs call Dr. Erik Jones Family Medicine at (208) 344-6080 immediately
- Sensitive subject matter (HIV/AIDS, mental health, work excuses, etc.…) is not permitted

PROPER SUBJECT MATTER FOR PORTAL COMMUNICATION:

- Medical questions, lab results, appointment requests and reminders, routine follow up questions, etc.…

CURRENT FUNCTIONALITY OF THE PATIENT PORTAL:

- Email and secure messaging for non-urgent needs
- Viewing of lab results that have been sent to you
- Viewing of selected health information (allergies, medications, current problems, past medical history)
- Referral requests
- Appointment requests and reminders

Because your login is tied directly to your Electronic Health Record in our office, you do not need to enter information such as phone numbers, addresses, UNLESS they are new or different than what you have given us before. All communications will be included in your patient health record.

PRIVACY:

- All messages are sent to you via a secure web portal
- Emails from you to any of our staff should be sent through this portal or they are not secure
- We will keep all email lists confidential and will not share them with any other parties
- Our staff members may read your messages or reply in order to help the clinician that has been emailed

RESPONSE TIME:

- We will normally respond to non-urgent email inquiries within 24 hours but no later than 3 business days after receipt.
- If we are unable to access email for any reason, we will attempt to have an automatic response inform you of this as soon as possible.

COST:

- At this time the portal access is free, though at some point in the future there may be a fee that will be billed in January annually.

All Policies and Procedures are subject to change without notice.

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PATIENT PORTAL CONSENT

Purpose: Dr. Erik Jones Family Medicine offers a secure way for our patients to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool but has certain risks. To manage these risks, we need to impose some conditions of participation. This form is, therefore, intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How it works: A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or passphrase to log in to the portal site. **We cannot give you a password over the phone there is a password reset function on the main page.**

How to participate: You can compose, pick up and reply to secure messages or view information sent to you through a web site hosted by our electronic health records company. This notification will give you the URL (internet address) of the web site where you can log in. You will then be able to log in using the username and password provided. Next you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the web site uses "secure sockets layer" technology, you can read or view information on your computer, but it is still encrypted in transmission between the web site and your computer.

You can access the portal through www.drerikjonesfm.com

Privacy Protection and Risks: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping messages secure depends on two additional factors: the secure message must reach the correct email address and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address, and we are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. If you think someone has learned your password, you should promptly go to the web site and change it. We understand the importance of privacy with regards to your health care and will continue to strive to make all information as confidential as possible. We will never sell or give away any private information, including email addresses, without your written consent.

Conditions of Participation: Use of the Patient Portal and appendix is governed by the terms and conditions of this informed consent and the policies and procedures. Please read this agreement carefully before accessing or using the Patient Portal. Access to this secure site is an optional service, and we may suspend or terminate it at any time and for any reason. We reserve the right at any time and from time to time to modify the Patient Portal site or documents or any part thereof, with or without notice. Any modifications made to this document, or its appendix will be effective immediately upon posting on the site. By accessing or using the Patient Portal, you agree to be bound by all terms and conditions of the Patient Portal as posted on the site at the time of your access or use. You agree to review the Patient Portal documents on the web site each time you use the Patient Portal so that you are aware of any modifications made to the Patient Portal documents. You agree not to hold Dr. Erik Jones Family Medicine or any of its staff liable for network infractions beyond its control. All site users represent and warrant that they are at least 18 years of age and that they possess the legal right and ability to agree to these terms of participation as set out in the Patient Portal documents and to use the site in accordance with these documents. We are offering this service free of charge until the end of the year at which time we reserve the right to charge an annual fee. We will provide adequate notice of such fees prior to them taking affect.

Before you were given this form, we provided you with our policies and procedures for using the Patient Portal. We need you to understand and comply with these, and by signing this form below you will acknowledge that they were explained to you and that you agree to comply with them. If you do not understand or do not agree to comply with our policies and procedures, do not sign this form. If you have any questions, we will gladly provide more information.

PRINT PATIENT EMAIL ADDRESS

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PRINT PATIENT NAME: _____

PRINT NAME OF LEGAL GUARDIAN/REPRESENTATIVE: _____

Please list below the names of persons, family, or friends, that you authorize our providers to disclose your private health information to. Married partners are not entitled to HIPAA status and therefore must be specified by the patient.

_____

_____

_____

_____

_____

_____

SIGNATURE OF PATIENT **OR** LEGAL GUARDIAN/REPRESENTATIVE DATE

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

AUTHORIZATION OF RELEASE OF PAYMENT

FINANCIAL OFFICE POLICY

FINANCIAL OFFICE POLICY CONTINUED

ANNUAL WELLNESS EXAM & LABS POLICY

MEDICATION REFILL POLICY

PATIENT PORTAL GUIDELINES, POLICY & PROCEDURES

PATIENT PORTAL POLICY

HIPAA - PRIVACY RULE DISCLOSURE OF PRIVATE HEALTH INFORMATION

I have read and understand these office policies. By signing this form, I am agreeing to that I have been notified and will adhere to the above guidelines. I will have all questions answered before signing.

PRINT NAME OF PATIENT **OR** LEGAL GUARDIAN/REPRESENTATIVE DATE OF BIRTH

SIGNATURE OF PATIENT **OR** LEGAL GUARDIAN/REPRESENTATIVE DATE

MEMBERSHIP AGREEMENT

& TERMS OF SERVICE

Please review the Assured Direct Care Terms of Service outlined below, sign and return prior to your first direct care appointment.

Erik S. Jones, DO PLLC offers you ("Patient") and enrolled family members a broad range of primary care medical and wellness services ("Direct Care Services") including, but not limited to those Services listed in Appendix A.

- Patient acknowledges that Erik S. Jones, DO PLLC is a membership ("Membership") Program offered by a private Practice ("Practice"). It is not insurance nor a contract of insurance nor does it provide health insurance coverage.
- Patient understands and agrees to become a member ("Member") of the Program and to the scope of coverage and Terms of Service, including limitations, of the Membership, as outlined in this Membership Agreement.
- Patient understands that the Practice must abide by all patient privacy rules and regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA).
- Patient understands and agrees to pay the monthly "Membership Fee" on or before the due date via ACH, participating employer contribution, or automated debit or credit card transaction using the payment information Patient has submitted and is on file at the Practice. The Patient understands that any Membership Fee transactions declined due to insufficient funds or expired cards will result in an additional fee of $50 per occurrence and that the failure to comply with the payment terms may result in termination of the Membership.
- The Patient may request medical services from the Practice in addition to those listed as Direct Care Services in Appendix A. Such additional services ("non-Direct Care Services") requested may be provided by the Practice and will billed at the time of service at the Practice's usual rate. The Patient will be solely financially responsible for the charges for these non-Direct Care Services. If these fees are not paid at the time of the services are received, the Patient will be required to submit payment within thirty (30) days of the service date.
- Patient understands that no Practice services will be rendered if there is a past due account.
- Patient understands that either the Patient or the Practice may terminate participation in the membership at will with written notice to Erik S. Jones, DO PLLC at 222 North 2nd Street, Suite 202 Boise, Idaho 83702. Written notice must be received 10 days before the next installment payment is due in order to stop future payments from being withdrawn.
- The Practice may decline a Membership enrollment or renewal of a Membership at any time.
- The Practice may terminate this Agreement at any time if the Patient: 1) fails to pay the Membership Fee or fees for additional medical services provided on a timely basis; or 2) violates the Practice's policies or instructions communicated to the Patient.
- Patient understands that the Practice may add, discontinue, or modify the Membership Services, the Membership Agreement, Terms of Service and/or Membership Fee at any

time. The Membership Fee will remain fixed per the Agreement for a period of at least 90 days from enrollment. Members will receive written notice at least 60 days in advance of any other change.

- The Patient understands that providers at the Practice are available for on-call telephone consultations outside of usual business hours in the event of a time-sensitive medical issue. The Membership does not include emergency department services. The Patient should call 911 or proceed to the nearest emergency department if immediate or life-threatening medical attention is required.

MEMBERSHIP FEE

The fee for Direct Care Services is as follows:

Description		**# Family Members Enrolled**
☐ First enrolled member	$79 /month	x 1 = $ 79
☐ Adult 26+ yrs	$79 /person/month	x _____ = $ _____
☐ Child/Dependent 0-25 yrs	$59 /person/month	x _____ = $ _____

Total __/month ***$____***

PAYMENT & ACTIVATION DETAILS

Automatic payment is required for the monthly Membership Fee via an automatic withdrawal from the payment source on file: ACH withdrawal from a checking account (preferred), employer contribution or charged to a credit/debit card. The automated payment will occur on the 1st Monday of every month. If that should fall on a holiday, your payment will be processed the next business day.

The Patient authorizes the Practice to withdraw the Membership Fee from the bank account, employer contribution, credit card or debit card on file until the Patient revokes such authorization or this Agreement is terminated in writing. Absent contrary instructions, the Patient also authorizes the Practice to charge the payment source on file for the payment of any additional Fees for non-Direct Care Services.

The Practice shall not bill any insurance plan, Medicare or Medicaid for any Direct Care Services provided to Patient. Patient may not submit any Direct Care Services to Medicare or any other Federal payer or HMO for reimbursement.

The Patient's Membership activation requires signed authorization of this Membership Agreement and Terms of Service by the Patient(s) and/or responsible party, if applicable, and the receipt of the Membership Fee. The Patient acknowledges receipt of the Practice's Payment and Office Policies. This Agreement shall be governed by the laws of the State of Idaho without application of choice-of-law principles. This Agreement replaces and supersedes all prior Agreements between the Patient and the Practice. This Agreement may only be modified in writing and must be signed by the Patient and an authorized representative of the Practice. If any term of this Agreement is deemed invalid or in violation of any law or regulation, the remaining terms of this Agreement shall remain in full force and effect. This Agreement may not be sold or transferred without the written consent of all parties. This consent requirement does not prohibit the presentation of Practice's marketing materials to groups of potential patients or their representatives. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Practice for all purposes.

For each Membership participant age Eighteen (18) years and older, a signature is required below.

RESPONSIBLE PARTY/PATIENT
Signature:

_____

Printed Name: _____
Date: _____

Signature:

_____

Printed Name: _____

Signature:

_____

Printed Name: _____

Signature:

_____

Printed Name: _____

☐ *I am also signing as the responsible party for my children, 17 years of age or less, who will be part of this Membership:*
Name:

_____

Name:

_____

Name:

_____

ERIK S.JONES, DO PLLC
Signature:

_____

Printed Name: Erik S. Jones DO
Title: Primary Care Physician
Date: _____

Return this Agreement to:
Erik S. Jones, DO PLLC

222 North 2nd Street
Suite 311
Boise, Idaho 83702

Phone: 208-344-6080 Fax: 208-344-6079

For office use only. Service effective date:

APPENDIX A
List of Direct Care Services

Visits
- 20 visits of at least thirty (20) minutes per visit in a 12 month calendar year
- Virtual Specialist consults
- Enhanced communication with direct phone line during business hours and after-hours texting
- Remote visits via teleconference

Preventative Care
- Weight management
- Health & wellness coaching
- Smoking cessation
- Women's health
- Wellness checks for infants and children

Health Management
- Chronic health conditions
- Comprehensive care & chronic care management
- Dermatology & skin cancer
- Mental health & wellness
- Anxiety, depression and attention deficit
- Therapeutic injections
- Sleep disorders
- Medication management
- Blood pressure
- Cholesterol
- Thyroid conditions
- Comprehensive diabetic care

Physicals & Check Ups
- Annual
- School/ sport
- Pre-employment
- Work/Return to work
- Pre-op

Urgent & Acute Care
- Colds and flu
- Rashes
- Lacerations and Injuries
- Minor orthopedic care
  Skin and other infections

Procedures
- Lacerations
- Skin Biopsies
- Burn/Wound care
- Warts
- Skin cancer

Testing
- Pregnancy testing
- Urinalysis
- Influenza A/B
- Strep throat*