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

NEW PEDIATRIC 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/PERSON:_____

SECONDARY PHONE:_____ CONTACT TYPE/PERSON:_____

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 RESPONSIBLE PARTY)

NAME _____ PHONE _____

RESPONSIBLE PARTY INFORMATION (PARENT OR GUARDIAN IF PATIENT IS A MINOR)

***PLEASE BE AWARE THAT THE ADULT WHO BRINGS IN A MINOR IS THE RESPONSIBLE PARTY**

NAME: _____
LAST FIRST MIDDLE

DOB: _____ SSN _____
MM/DD/YYYY

_____
ADDRESS 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.

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.

HEALTH SHARE INSURANCE PLANS:

- We will no longer be billing any office services to Health Insurance Plans, this includes office visits, labs, vaccines, and any other in-office procedures or testing.
- **Patients with these plans will be considered "Self-Pay," and will be required to pay for these appointments in full.** Patients can then submit their payments to their insurance plans for reimbursement.
- Patients can pay at the time of service for a discounted price or can request to be billed for the balance. Please ask the front desk about cash prices.
- If you are concerned about cost, we suggest discussing coverage of any office services with your insurance prior to receiving them.

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.

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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.

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.

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.

We appreciate the opportunity to provide your healthcare services. The following is a statement of agreement with our financial office policies.

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

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IN-NETWORK HOSPITAL FACILITIES

Our clinic is privately owned and is not connected to either local hospital network; St. Luke's or St. Alphonsus. While our providers hold privileges at both hospitals, we are a separate entity.

Many insurance plans will have a preference or strict in-network facility policy that requires their customers to use either St. Luke's hospital network or St. Alphonsus' hospital network. Some insurance companies will notate their preference on your insurance card, most will not.

We will need patients to inform our clinic staff of which hospital network their insurance prefers should the need for a specialist referral, advanced imaging, or pathology services arise.

PATIENT INSTRUCTIONS:

- **If you are unaware of your insurance company's in-network requirements**, please call the Member Services Number located on the back of your insurance card.
- **If your insurance carrier does not have a preference**, please note this on the "Patients Insurance Preferred..." line below. Clinic staff can discuss facility options that best suit your needs.
- **Failing to inform the clinic of your in-network preferences can cause unnecessary out-of-pocket costs, delays in ordering imaging, or specialist referrals.** Patients are liable for any expenses resulting from out-of-network costs.
- For patients that do not clarify their preferred pathology laboratory, **our clinic will send your sample to St. Alphonsus. You will be responsible for any corresponding pathology bills from their laboratory.**

Please note below which hospital facility your insurance prefers, **St. Luke's or St. Alphonsus.**

Patients Current Insurance Carrier Date

Insurance Preferred In-Network Facility Date

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ESTABLISHING CARE APPOINTMENTS & ANNUAL WELLNESS EXAM POLICY

All patients Establishing Care or Re-establishing Care are allotted a one-hour appointment time. At this visit our providers will work to establish a clear medical history, as well as create a personalized plan to help keep you healthy over the next few years.

This 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.

Our clinic accepts many insurance carriers, to provide the most inclusive and complete services possible, we do not restrict our appointment topics to any one carriers' guideline of an "Annual Wellness Visit."

THIS APPOINTMENT IS NOT AN ANNUAL WELLNESS VISIT; however, it will include many of the same elements:

- A complete review of 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.

All Establishing Care appointments will be billed to insurance as a "New Patient Appointment." Copays will be expected at the time of service. Patients with deductible plans, or those who receive additional medical services, will be billed following insurance remittance.

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 has different guidelines.

If you have concerns about which appointments, services, or labs are covered or not covered, we encourage you to reach out to your insurance carrier, as each plan will vary.

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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).

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HIPAA
Privacy Rule Disclosure of Private Health Information

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.

_____

_____

_____

_____

_____

_____

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FINANCIAL OFFICE POLICY

FINANCIAL OFFICE POLICY CONTINUED

IN-NETWORK HOSPITAL FACILITY

ESTABLISHING CARE APPOINTMENTS & ANNUAL WELLNESS EXAM POLICY

MEDICATION REFILL POLICY

IDAHO HEALTH DATA EXCHANGE

HIPAA - PRIVACY RULE DISCLOSURE of PRIVATE HEALTH INFORMATION

I have read and understand these office policies. By signing this form, I am agreeing that I have been notified of, and will adhere to, the above guidelines. I will have all questions answered before signing. Failure to sign does not void patient of responsibility to adhere to office policies and procedures.

PRINT PATIENT NAME DATE OF BIRTH

PRINT NAME OF LEGAL GUARDIAN/REPRESENTATIVE DATE

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