606 N. 3rd Ave Suite 101
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Ph#208.263.1435
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Scott Dunn, MD
Zach Halversen, MD
Dan Meulenberg, MD
Hannah Raynor, MD
Jeremy Waters, MD
Kara Waters, DO
Emilie Kuster, FNP

Welcome to Family Health Center! Where healthcare is a team approach with you, the patient, at the center of your own care.

Here are a few things you need to know:

- If your insurance requires you to designate a PCP please contact them ***prior to your appointment*** to let them know you have changed physicians or they may not pay for your visit. That means you may get a bill for the full cost of the visit.
- Please bring your insurance card and current driver's license with you to your appointment.
- Regarding your previous medical records – If you have copies, please bring them to your appointment. If not, we can further assist.
- Please complete your new patient paperwork **24 hours** prior to your appointment and return it to us before we see you. If we do not have your paperwork we may have to cancel your appointment.
- If you are taking pain medications please talk with our front office staff.
- Visits for a motor vehicle accident must be paid for at the time of service. We do not bill attorneys or auto insurance carriers. Our billing department will be happy to provide you with a copy of the bill for your records.
- If you have a work related injury please call the office to provide us with the necessary information before we can schedule an appointment.

Thank you for choosing Family Health Center for your medical needs!

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Newborn New Patient Paperwork

Child's Last Name: ____________________ First Name: ________________ Middle Initial: ____ Nickname: __________
Birthdate: ______________________ Age: ______ Gender: ______ SS#: ____________________________

Child's Mailing Address: ______________________________ City: ____________________ St: ____ Zip: ________

Patient Insurance: __________________________________ Policy #: _________________________________

Mother's Last Name: __________________ First Name: ____________ Birthdate: _________ Phone: ______ ______

Mother's Address: ________________________________ City: ____________________ St: ____ Zip: ________

Social Security #: _______________________ Email Address: ____________________________________

Employer's Name: ____ Work Phone: _________________________

Father's Last Name: __________________ First Name: ____________ Birthdate: _________ Phone: ______ ______

Father's Address: ________________________________ City: ____________________ St: ____ Zip: ________

Social Security #: _______________________ Email Address: ____________________________________

Employer's Name: ____ Work Phone: _________________________

Does this child primarily live with: ☐ Father ☐ Mother ☐ Other Adult ____

Does this child at times live with adults other than above? ☐ Yes ☐ No

Name ____ Relationship __________________________

Address ____ Phone ______________________________

Preferred Contact	Ethnicity	Race
☐ Mail	☐ Hispanic/Latino	☐ American Indian or Alaskan Native
☐ Home Phone	☐ Non-Hispanic	☐ Asian
☐ Cell Phone		☐ Black or African American
☐ Patient Portal		☐ Native Hawaiian/Other Pacific Islander
☐ E-Mail		☐ White
		☐ Other

How would you like us to remind you about your child's future appointments? (Choose one)

☐ Voice Reminder (# we should call) _________________________

☐ Text message (# we should text) _________________________ *(Data message rates may apply-contact your carrier)*

☐ E-mail ____

How did you hear about us? ☐Employer ☐Family Member ☐Friend ☐Google/Web ☐Insurance Co ☐Previous Patient ☐Referral
☐ Other: ______________________________

What doctor / clinic have/has taken care of this child in the past? ____

Consent for treatment:

1. By signing below I give permission for Sandpoint Family Health Center to give me medical treatment.
2. I allow **Sandpoint Family Health Center** to file for insurance benefits to pay for the care I receive.
    a. I understand that **Sandpoint Family Health Center** may have to send my medical record information to my insurance company.
    b. That I must pay my share of the costs.
    c. That I must pay for the cost of these services if my insurance does not pay or if I do not have insurance.
3. I understand that I have the right to refuse any procedure or treatment.
4. I have the right to discuss all medical treatments with my clinician.

X______________________________________ ______________________
Signature of Patient/ Parent Date

X______________________________________ ______________________
Printed Name of Patient/ Parent Date

Patient Financial Agreement

Thank you for choosing Sandpoint Family Health Center as your health care provider. We are committed to providing quality, comprehensive, and patient centered care while building a successful physician-patient relationship. An important part of that relationship is your clear understanding of our Financial Policies. To help you understand, we ask that you carefully read this policy. If you have any questions about this information, please ask to speak with a member of our billing staff.

Billing Insurance and Patient's Responsibility

In order to properly bill your insurance company, we require that you disclose all current insurance and demographic information. At each visit, please provide us with your insurance card and any changes to your name, address, or contact information. While every effort is made to collect from the insurance companies, patients are responsible for denied charges due to inaccurate insurance information.

We will do our best to help you understand your insurance benefits. However, it is ultimately your responsibility to know your benefits. The insurance company makes the final determination of your eligibility and benefits for services rendered, which may result in additional costs. We encourage you to contact your insurance company if you have any questions regarding your eligibility or benefits prior to your appointment.

If you have a concern regarding cost, please discuss any additional procedures with your physician *before* they are started.

Self-Pay or Private Pay

If you have no insurance coverage, we will provide an estimate for the services requested at the time of scheduling. We offer a 15% discount on all professional charges to self-pay patients. This discount does not apply to procedures, labs, immunizations, or other in-office services. A $100 down payment is due when you check in and the balance due at the end of your appointment. Please talk with our billing specialist if you would like to discuss a payment plan.

Payment Expectation and Collection Policy

Co-Pays are due at the time of your visit. If you do not pay your co-pay a $10.00 fee will be assessed.

In the event you acquire a past due balance, we will make several attempts to notify you using the contact information you provide. If there is no response to our efforts within ninety (90) days, the balance will be turned over to our collection agency. We may not schedule any future appointments until your past due balances are paid in full.

My signature certifies that I have read and understand the contents of the Patient Financial Agreement.

______________________________ Print Name

____________________ Date of Birth

______________________________ Signature

____________________ Date

Acknowledgement of Notice of Health Information Practices

This Notice explains when we might use/disclose your health information, and includes some of the following examples:

When you give us permission to disclose your health information

- To aid in your treatment or to persons involved in your health care
- To help us or other health care providers get paid for services provided to you
- To public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- Right to ask that information about you not be disclosed to certain persons
- Right to restrict disclosures of PHI to your health plan when you pay out of pocket in full for a healthcare item or procedure
- Right to ask that we communicate differently with you to ensure your privacy
- Right to look at and get a copy of most of your health information in our records
- Right to request that we correct health information in your record that is wrong or misleading
- Right to be notified when a breach of your health information has occurred
- Right to have us tell you whom we have disclosed your health information
- Right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services

I acknowledge that I have been given an opportunity to review this facility's Full Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have. (*This is NOT the complete Notice of Health Information Practices. If you would like the full copy it is available by request or by visiting our website at www.fhcsandpoint.com.)*

X______________________________________

Signature of Patient/ Parent

____

Date

X______________________________________

Printed Name of Patient/ Parent

____

Date

Pregnancy and Birth

(Only fill out if child is currently younger than 12 months old)

Where was baby born? ____

Birth Weight ________ Birth Length ________ Age of Mother at Baby's birth ______

Infant's gestational age: ☐ Full term ______ ☐ Preterm _____ If so, how many weeks ______ ☐ Post term ______

Type of Delivery: ☐ Vaginal _____ ☐ C-section _____ If so, reason ________________________________

Were there any medical problems during the pregnancy (i.e., diabetes, infections, high blood pressure, breech presentation, preterm labor), Labor or Nursery? ________________________________

Did baby experience any jaundice? ☐ Y ☐ N

Did baby have their newborn hearing test? ☐ Y ☐ N

Did baby have their PKU test (also known as Newborn Health Screening / Heel Poke) ☐ Y ☐ N

Medications – List all medications your child takes, prescription and non-prescription, and the dosage		
	☐ ***No Medications***	
Medication Name	**Dosage**	**Frequency**

Medication & Food Allergies – List all known allergies (drugs, food, animals, etc.)	
☐ ***No Allergies***	
Allergy	**Reaction**

Family History – Check if any family member(s) has had any of the following conditions and age of onset																	
Is child adopted? ☐ Yes ☐ No																	
Relationship to child	Alzheimer's	Anxiety	Alcoholism	Asthma	Blood Disorder	Depression	Diabetes	Heart Attack	Heart Failure	Hypertension	High Cholesterol	Renal Disease	Schizophrenia	Stroke	Thyroid Disorder	Cancer – list type and age below	**Alive?** *Mark Yes or No*
Father Age of onset?																	Cause of death and age:
Mother Age of onset?																	Cause of death and age:
Sister(s) Age of onset?																	Cause of death and age:
Brother(s) Age of onset?																	Cause of death and age:

Is there anything else you would like to know about your child's medical history?

____

____

____

____

Thank you for choosing Family Health Center to provide you with your medical care. We look forward to getting to know you and your family!