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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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Your New Medical Home

Family Health Center is a Patient-Centered Medical Practice dedicated to the health and wellness of the patients and community we serve. Our certification as a Patient-Centered Medical Home (PCMH) means our physicians and staff are committed to comprehensive, personal healthcare centered around you; partnering with you to ensure all of you and your family's medical and non-medical needs are met.

Your Personal Physician

The relationship between you, your physician, and the care team is the driving force behind a Patient-Centered Medical Home. Your physician will provide medical care that is right for you based on evidence-based guidelines shown to improve health.

Your Care Team

Your physician will direct the care team to coordinate your care based on YOUR wants and needs.

To improve efficiency, the care team will plan for your appointment by:

- ✓ reviewing your medical chart for up-to-date forms.
- ✓ check for recent testing.
- ✓ ensure you are notified of results in a timely manner.
- ✓ coordinate your healthcare across all care settings including the medical office, hospital, behavioural health, testing facilities and other places where you may receive care.

If you are admitted to the hospital, you will receive a phone call from your care team upon your discharge to review your hospital stay, make sure you return for follow-up care, and discuss any questions or concerns you may have about your treatment or medications.

Your Health

In return, we ask that you be an active participant in your health care. We ask that you take charge of your health by managing and monitoring aspects of your care.

You should:

- ✓ Let us know if there are any changes in your medications and bring a list of your medications with you to your visits.
- ✓ Let us know if you are getting care from other healthcare providers, any hospitalizations, or ER visits.
- ✓ Tell us about any complementary and natural treatments you are getting.
- ✓ Provide a complete medical history so you get the best care possible.
- ✓ Identify previous doctors so our medical records staff can request important notes and test results.

Quality for you

As a PCMH we are committed to providing same day appointments and offering expanded hours to meet your needs. We will use our electronic health record to support the best care, quality, and safety by helping us to identify and provide for your needs and the needs of our entire patient population. We are able to communicate with you electronically through our secure Patient Portal, along with sending you reminders for appointments and preventative or chronic care services due.

If you ever have any questions please just ask. Your care team is here to help!

Thank you for choosing Family Health Center as your Medical Home!



Pediatric 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 _____

<p>Preferred Contact</p> <p><input type="checkbox"/> Mail</p> <p><input type="checkbox"/> Home Phone</p> <p><input type="checkbox"/> Cell Phone</p> <p><input type="checkbox"/> Patient Portal</p> <p><input type="checkbox"/> E-Mail</p>	<p>Ethnicity</p> <p><input type="checkbox"/> Hispanic/Latino</p> <p><input type="checkbox"/> Non-Hispanic</p>	<p>Race</p> <p><input type="checkbox"/> American Indian or Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Native Hawaiian/Other Pacific Islander</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Other</p>
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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/Guardian

Date

X _____
Printed Name of Patient/Guardian

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.

X _____
Signature of Patient/Guardian

Date

X _____
Printed Name of Patient/Guardian

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/Guardian

Date

X _____
Printed Name of Patient/Guardian

Date

Last Name: _____ First Name: _____ DOB: _____

Reason for today's visit: _____

Preferred Pharmacy: _____

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

Growth and Development

Are there any problems with the child's behavior in the home? Yes No If yes, please explain:

If child is old enough for school, are there any school problems (learning, social, behavioral, coordination)? Yes No If Yes, please explain:

Has your child had any of the following?

	Yes	No	Date		Yes	No	Date
Anemia				Heart trouble / murmur			
Appendicitis				Inability to get to sleep?			
Asthma				Kidney disease			
Bladder infection				Loss of urinary bladder control?			
Bleeding with bowel movements				More than six colds in a year?			
Bloody, red or brown urine				More than two earaches in a year?			
Broken Bones				Pneumonia			
Chickenpox				Rheumatic fever			
Chronic cough/frequent bronchitis				Shortness of breath with exercise?			
Concussion(s)				Stuffy nose most of the time?			
Convulsions/seizures				Treated for accidental poisoning			
Eczema/sensitive skin				Tonsil-Adenoid surgery			
Fainting spells				Trouble hearing			
Frequent bad stomachaches				Unconscious from an injury			
Frequent nightmares				Weak eye muscles (cross eyes or wall eyes)?			
Frequent urination?				Whooping cough			
Frequent vomiting?				Other serious injuries: _____			
Headaches more than twice a month?				Hospitalized for reasons other than those listed: _____			

Health and Safety

	Yes	No		Yes	No
Does your child get regular dental cleanings?			Is the hot water temperature set to less than 125 degrees?		
Does your child use a car seat or seat belt all the time?			Do you have rules/limits for screen time?		
Are there smoke detectors in your home?			Are medicines or potential poisons out of reach?		
If there are guns in your home are they locked up?			Is there an adult in your household who knows child CPR?		

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!