PCS
PRIMARY CARE SPECIALISTS

OFFICE USE ONLY
Information is complete

Initials_____

Mark Mansfield, MD
Richard Maynard, DO

FINANCIAL POLICY

Patient Name: _____ **DOB:** _____

Thank you for choosing our office to provide for your health care. We are committed to providing you and your family with the best possible care for you and your family. Our staff looks forward to assisting you and making your visit a pleasant one. We have designed our fees to reflect the care and quality of service you should expect to receive. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of your insurance plan and our payment policy. We accept cash, checks, debit, Discover, American Express, Master Card and Visa credit cards.

- Payment is due at the time services are rendered. A $7 charge will be added to accounts to redeposit checks for non-sufficient funds. If it comes back a second time, a $15 charge will be added to account for non-sufficient funds. Balances older than 30 days will be subject to additional **finance charges** of **1.5%** per month (18% APR) or a minimum of $1.00. By signing below, you agree to be responsible for finance charges and for collection costs to include: a certified mail fee not to exceed $10 to notify you if this account is turned to collections; return check fees up to $20 per occurrence; plus, reasonable court costs and attorney's fees should legal action be required to collect this account as agreed. If for any reason the account should be delinquent, the responsible party agrees to pay up to a thirty percent (30%) collection fee of the unpaid balance; together with all legal fees, with or without suit, including reasonable attorney fees and costs. Payment arrangements set up on automatic withdrawal will be given a 5-day grace period from the due date. After 5 days, if the current month's payment is still owing, the account will be charged a $5 late fee.
- If you have not met your deductible, we ask for payment in full at the time of service as no insurance benefit will be paid. If your deductible has been met and you have paid your account in full, we will issue a refund check to you upon receipt of the insurance payment. ***Please call your insurance prior to your appointment to find out what your deductible is and if it has been met.*** This will speed up the check-out process.
- Please check with your insurance prior to having a Wellness Exam for coverage questions. We **cannot** rebill office exams that have been denied by your insurance company.
- Your insurance is a contract between you and the insurance company. We are not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc.
- If you are being seen due to Workmen's Compensation or an accident, please be sure to inform us of the details of your accident, as well as the name, address and claim number needed to bill for the visit. We will not get involved in a dispute for payment. If not paid in 60 days, it will become patient responsibility.
- **Divorce decrees**: This office is not a party to a divorce decree. Adult patients are responsible for their bill at the time of service. The financial responsibility for Minors rests with the accompanying adult.
- **Minor patients**: The adult accompanying a minor is responsible for payment at the time of treatment. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by a parent/guardian. Payment is still expected at the time of service.
- A ***combined visit*** is when the physician or midlevel provides Wellness services ***and*** medical care/follow up on the same date. Insurance companies encourage and usually cover annual wellness visits. In the past, your medical visit may have been a separate visit where prescriptions are reviewed and refilled, the current status of chronic conditions are evaluated, and new conditions or concerns can be addressed. Most insurance companies usually cover a combined visit. This is a great convenience to you, our patient. You can choose whether to take care of both services at once ***or*** to schedule back at a later date for a separate visit. The services for a combined visit will be billed out separately. For most patients, a Wellness will be paid at 100% and a co-pay/deductible will apply to the office visit.
- Primary Care Specialists would enjoy the opportunity to extend professional courtesy discounts; however, we have been advised against this practice as it is a violation of Health Care Financing Administration guidelines. Idaho Code Section 41-348 prohibits the regular practice of waiving, rebating, giving, paying (or the offer to do the same) a claimant's deductible. This practice is also illegal under federal law (2002 OIG Special Advisory Bulleting "Offering Gifts and Other Inducements to Beneficiaries"). In accordance with the HIPPA 1996, False Claims Act, and the anti-kickback statute, we regret that we are unable to extend discounts except in extreme financial hardship cases.
-

I have read, understand, and agree to the guidelines in this Financial Policy:

Sign and Acknowledge: _____ **Date:** _____

Printed Name: _____ **Relation to Patient:** _____

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Demographics Form

Name (Last, First, Initial): _____ DOB: ___/_____/_____
Mailing Address, City, State & ZIP: _____
Home Phone #: _____ Cell Phone #: _____ Sex: _____
Social Security#: _____-_____-_____ Marital ***Status (circle one)*****:** S M D W Other
Language:**(Please circle one)** English Spanish Other _____
Race: ( ) African American ( ) American Indian ( ) Asian ( ) Hispanic ( ) Native Hawaiian ( ) Other ( ) White
Appointment Reminder Preference (circle one): Text Home Phone Cell Phone
Communication: ( ) Deaf ( ) Hard of Hearing ( ) Blind ( ) Other _____
Primary Doctor (circle one): Mansfield Maynard
Email Address: _____ Would you like access to the Healthlife Portal: Yes No

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Guardian/Primary Responsible Party: _____
Address, City, State & ZIP: _____
Birth date: _____/_____/_____ Sex: _____ Social Security#: _____-_____-_____
Patient Relationship to responsible party: ( ) Same ( ) Spouse ( ) Child ( ) Other

Emergency Contact: **(Name, Address, Phone# & Relationship**): _____
_____

If you have a caregiver who assists in your care, please make sure the office has the appropriate paper (legal) documentation for your account. If you do not already have one, please ask the receptionists for an "Authorization for Access to Account" form to fill out.

Insurance information (Please also bring the card(s) with you)

1) Primary Insurance: _____ Employer: _____
Policyholder's Name: _____ Birthdate: _____ Sex: _____
Policy Number: _____ Group Number: _____

2) Secondary Insurance: _____ Employer: _____
Policyholder's Name: _____ Birthdate: _____ Sex: _____
Policy Number: _____ Group #: _____

Assignment of Benefits

I hereby instruct and direct my insurance company to pay by check made out and mailed to: Primary Care Specialists, 110 Vista Dr., Pocatello, Idaho 83201 for the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am financially responsible for any non-covered services. I also authorize Primary Care Specialists to release any information required to process claims.
In signing below, I indicate that the information provided is correct to the best of my knowledge. ***I give my consent for medical care provided by Primary Care Specialists.***

_____ _____
Signature of Policyholder **&/or** Primary Responsible Party Date

Yearly Health Update **Today's Date: ____/_____/_____**

Patient Name (Last, First, Initial): _____ DOB: _____/_____/_____

Status (circle one): Married Single Divorced Widow Other Occupation: _____

Communication: **(Please circle one)** Deaf Hard of Hearing Blind Other _____

Advanced Care Planning *(ie: POA, End of Life, Advanced Directives):* _____

Medications: (Name, Dose, and when taken) _____

_____

Allergies to medicines: (Yes/No/What Medications?) _____
Surgeries: (What did you have and when) _____

_____

Medical History: (List all hospitalizations, or any chronic medical condition for which you've seen a doctor) _____

_____

Social History:
Have you/Do you use illicit/recreational drugs? If so which ones? _____

If you drink alcoholic beverages, how much & how often? _____

If you chew, smoke or have ever used tobacco, what age did you start? How much do you use a day? _____

Any other social history? *(ie: vaping, literacy, housing, etc.)* _____

Your Family History: (Any diseases or illnesses in children, parents, or grandparents.)			
Name of family member	Age	Health Problems	Cause & Age at Death
Mother:			
Father:			
Siblings:			
Maternal Grandmother:			
Maternal Grandfather:			
Paternal Grandmother:			
Paternal Grandfather:			
Children:			

Name: _____ ***Date:*** _____

Please check any boxes that are <u>current</u> problems you would like to discuss with the provider. This sheet is <u>confidential</u> and is private information between you and your provider. New patients should fill out completely. If this is a <u>past</u> condition, indicate date next to problem.

Habits
- ☐ Smoke cigarettes or chewing tobacco
- ☐ 2 or more alcoholic drinks daily
- ☐ Use recreational drugs
- ☐ Don't exercise regularly

Nutrition
- ☐ Like salt and salty foods
- ☐ Weight gain/ loss of >15 lbs in past 1 year
- ☐ Regularly eat fast food, cakes, cookies
- ☐ Would like help with diet

Blood & Lymphatic
- ☐ Frequent infections
- ☐ Have you had a blood transfusion
- ☐ Do you have anemia
- ☐ Lumps in neck, armpits, or groin

Skin, Nails, & Hair
- ☐ Hair loss
- ☐ Nail Change
- ☐ Excessive itching
- ☐ Dry skin
- ☐ Rash
- ☐ Abnormal sore/mole/growth
- ☐ Changing moles (color or shape)
- ☐ Unwanted birth marks
- ☐ Unusual or Excess Hair Growth
- ☐ Acne

Breasts
- ☐ Nipple discharge/bleeding
- ☐ Skin dimpling
- ☐ Pain
- ☐ Change in size
- ☐ Lumps
- ☐ Family history of breast Cancer

Sexuality
- ☐ Have Birth control needs
- ☐ Would like to discuss sexual concerns
- ☐ Worried about past sexuality
- ☐ Want HIV test

Head
- ☐ Have you had a severe head trauma
- ☐ Severe headaches
- ☐ Early morning headaches
- ☐ Sinusitis
- ☐ Allergies
- ☐ Visual loss
- ☐ Double vision
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Frequent nose bleeds
- ☐ Vision Exam: _____
- ☐ Do you take an Aspirin daily?

Neck /Mouth
- ☐ Stiffness
- ☐ Masses
- ☐ Voice hoarseness
- ☐ Lip/Gum/Mouth sores

Lungs
- ☐ Get excessively sleepy while driving
- ☐ Blood clots
- ☐ Asthma
- ☐ Snore loudly at night
- ☐ Emphysema/COPD
- ☐ Tuberculosis or exposure to TB
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Pain with breathing
- ☐ Stop breathing at night

Cardiovascular
- ☐ Wake up at night short of breath
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Chest pressure, pain or tightness
- ☐ Irregular heartbeat
- ☐ Shortness of breath on exertion
- ☐ Can't sleep flat
- ☐ Urinate more than once after bedtime
- ☐ Ankles swell
- ☐ High blood pressure
- ☐ Do your feet get cold easily?

Neurological/Musculoskeletal
- ☐ Loss of consciousness
- ☐ Memory loss/forgetfulness
- ☐ Confusion
- ☐ Stroke
- ☐ Numbness/tingling _____(location)
- ☐ Dizziness
- ☐ Back Pain
- ☐ Other Pain _____

Prevention Year of most recent:
- ☐ Pap Smear_____
- ☐ Breast Exam _____
- ☐ Mammogram_____
- ☐ Digital Rectal Exam _____
- ☐ Test for blood in stool _____
- ☐ Sigmoidoscopy _____
- ☐ Colonoscopy _____
- ☐ Bone density test _____
- ☐ TB Skin Test _____
- ☐ Tetanus Immunization _____
- ☐ Flu Shot _____
- ☐ Hepatitis C test _____
- ☐ Pneumonia Shot _____
- ☐ PSA Prostate blood _____
- ☐ Cholesterol Test _____

Gastrointestinal
- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Acid Reflux
- ☐ Heartburn or indigestion
- ☐ Food intolerance
- ☐ Nausea or vomiting
- ☐ Vomiting of blood
- ☐ Ulcers
- ☐ Abdominal pain
- ☐ Hepatitis/liver disease/jaundice
- ☐ Gall bladder disease
- ☐ Pancreatitis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stools
- ☐ Black stools/Black tarry streaks in stools
- ☐ Family history of colon polyps
- ☐ Family history of colon cancer
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Stool incontinence

Genitourinary
- ☐ Kidney stones
- ☐ Burning with urination
- ☐ Urinary frequency/urgency
- ☐ Blood in urine
- ☐ Difficulty starting urine
- ☐ Infertility
- ☐ Urine incontinence/Leaking

<u>MALE</u>
- ☐ Impotence/ejaculatory problems
- ☐ Scrotal/testicle mass or enlargement
- ☐ Hernia
- ☐ Prostate problems
- ☐ Family history of prostate cancer
- ☐ Weak urine stream
- ☐ Penile lesion/discharge/STDs

<u>FEMALE</u>
- ☐ Bleeding after menopause
- ☐ Abnormal periods
- ☐ Sores/lesions/STDs
- ☐ Vaginal discharge/itching
- ☐ Pain with intercourse
- ☐ Abnormal pap smears
- ☐ Hot flashes
- ☐ Bleeding after intercourse

Psychiatric
- ☐ Mood problems
- ☐ Anxiety
- ☐ Concentration problems
- ☐ Suicidal thoughts
- ☐ Need counseling

Are there any other medical problems not listed above you would like to discuss: _____

_____

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PATIENT NOTICE
OF INFORMATION PRIVACY PRACTICES

(Pursuant to the Health Insurance Portability Act, Public Law 104-191)

At Primary Care Specialists, we have always believed our patients are entitled to seek treatment in an environment where they are treated by a professional staff, with dignity, and where their privacy is respected and protected. We are responsible for maintaining such a clinic environment and have historically practiced stringent policies and procedures to ensure that we do so.

Effective in April 2003, Health Care Practitioners and facilities in the United States are required by regulations provided for in the Health Insurance Portability Act (HIPAA) to notify their patients of the policies and practices they will follow in the safeguarding of patients' private health information at it is used in treatment, obtaining payment (including the submission of insurance claims electronically), and other health care operations within the practitioner's facility.

The Office of the Secretary of Health and Human Services acknowledges in documents posted on its website in December of 2002 that "Health care providers have a strong tradition of safeguarding private health information." However, in today's world of increased computerization and electronic transmission of information, federal regulations have been developed to mandate standards for the protection of patients' private health information as it is used in internal health care facility operations and to govern its transmission or disclosure to entities outside of the practitioners' own facilities.

The following sections of this document describe Primary Care Specialists' practices for safeguarding your private health information. At the end of these sections, you will find an **Acknowledgement of Receipt of Notice of Privacy Practices**. Please sign this acknowledgement and return it to one of our staff members so that we can comply with the new federal regulation and demonstrate that we have notified our patients of our privacy practices and the patient's rights regarding access to his or her private health information.

Section I: ROUTINE USES AND DISCLOSURES OF HEALTH INFORMATION

Primary Care Specialists gathers documents and organizes information about you into records held in our patient charts and our patient accounting system solely for the purpose of providing you with appropriate medical treatment and service and to obtain payment for those services. Provision of treatment sometimes requires that we share information with other physicians (or their employees) who are involved in your treatment and with emergency personnel such as paramedics and hospital emergency room physicians and staff. For sports injuries, this may also include athletic trainers, physical therapists, and coaches.

Section II: OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

Other health care operations we conduct in which we may use or disclose your personal or health information include **patient appointment reminders, or notifying you of clinical results, treatment plan instructions by phone, and in participation with the Statewide Healthcare Innovation Plan (SHIP), and the Idaho Health Data Exchange (IHDE). To opt out please go to http://www.idahohde.org/opt-out-or-opt-back-in/ or ask a receptionist for a copy of the form.**

There may also be situations in which we are required to disclose information by federal or state law. However, in these situations we are careful to protect the confidential relationship that must exist between a health care practitioner and his or her patient. We will release only what is required by law and are diligent to be certain that we are, in fact, required to disclose information before we will do so.

Section III: USES AND DISCLOSURES PURSUANT TO WRITTEN AUTHORIZATION

Except for the purposes described above in Sections I and II, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke that authorization at any time. For example: If you give your written permission to provide medical records related to an auto accident to an attorney, you will have the right to revoke that authorization so that no subsequent treatment records after that date would be given by us to the requesting attorney.

Section IV: YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information:

A. You may request (in writing) a copy of the health information we maintain and utilize in making decisions about your care. (We have a right to deny your request in some very limited circumstances; you have a right to appeal a denial).

B. You have a right to request that we amend (or correct) information documented or created by us and maintained in your chart. We have a responsibility and a right to maintain our patient charts with information that is accurate and appropriate to support good medical treatment of our patients. Any decisions we make regarding your request for amendment of information will be based on careful consideration of these.

C. You have a right to an accounting of disclosures we have made (not including those involved in routine communication with other practitioners involved in your care or to emergency personnel in emergency situations).

D. You have a right to request restriction or limitation of the information we disclose about you for treatment, payment or health care operations. For example, you may ask that we not disclose or submit information to your insurance company about a particular treatment you received. (Such a request should be made in writing and be made prior to your receiving that treatment).

E. You have a right to request confidential communications regarding your health care. For example, you may ask that we only try to contact you at home and never at work.

F. You have a right to receive a paper copy of this notice. Further, we are willing to share with you any more information that you might request and that we have regarding patient privacy policies.

Section V: QUESTIONS OR COMPLAINTS

If you have any questions regarding this Notice or if you wish to receive additional information about our privacy practices, please contact a member of our clinic management staff at (208) 234-2300. If you believe your privacy rights have been violated in any way and want to discuss it with someone outside of the clinic, you may contact the Office of the Secretary of Health and Human Services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received a copy of Primary Care Specialists' Notice of Privacy Practices.

_____ _____ _____

Patient Signature or Child's Name Date of Birth Date

_____ _____

Patient Legal Representative (If Applicable) Date

_____ _____

Print Name of Legal Representative Relationship to patient

FOR CLINIC USE ONLY:

Primary Care Specialists made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.