MORGAN FAMILY MEDICINE

1660 S Woodsage Ave, Bldg. A
Meridian ID 83642
Ph: 208-906-1231
Fax: 208-906-1232

Today's Date: _____ Date of Birth: _____

Legal Patient Name: _____ Preferred Name: _____

Address: _____ City, State, Zip: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widow ○ Child Race: _____ Ethnicity: _____

○ Male ○ Female Gender Identity: _____ Hispanic or Latino: ○ Yes ○ No

COMPLETE ONLY IF PATIENT IS A MINOR OR NOT THEIR OWN GUARANTOR

Complete Name of Guarantor: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ ○ Please text/email me Email: _____

Insurance Carrier: _____ ○ I have secondary insurance, too!

Group Number: _____ Member ID: _____

Your relationship to Subscriber: SELF SPOUSE CHILD Subscriber is ○ Male ○ Female

Subscriber's Name: _____ Subscriber's Date of Birth: _____

CLINIC POLICIES AND PRACTICES

By INITIALING below, I agree:

_____ I agree and understand that other patients will be receiving medical care during my visit and may overhear information regarding my plan of care.

_____ I agree that a Registered Nurse or Medical Assistant or a nursing student or a medical assistant student may assist in my care.

_____ I agree that I must check in and check out at each visit and understand that subsequent visitors may have the opportunity to see and/or hear my name.

_____ I agree with Morgan Family Medicine's scheduling policy – I will attend all appointments as scheduled or I will cancel by providing 24-hour notice. I understand there is a $35 fee for all appointments I do not attend that I do not cancel or reschedule by providing a 24+ hour notice.

_____ I agree to receive my billing statements electronically via patient portal, email, and text message.
○ I decline paper statements and request paper statements.

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FINANCIAL POLICY AND GOOD FAITH ESTIMATE REQUESTS

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. If your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee scheduled, you will be responsible for the remaining difference. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment to Morgan Family Medicine, LLC (MFM).

Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter.

If you do not have insurance or if our provider is considered Out of Network with your insurance provider, you are encouraged to ask for a Good Faith Estimate and one will be provided to you, in accordance with The No Surprise Billing Act of 2022.

Morgan Family Medicine LLC does not bill Workman's Compensation insurances.

By signing below, I understand and agree that my account if paid within 90 days of my discharge will be interest free and after 90 days my account will be subject to a 12% interest APR. If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

GENERAL CONSENT FOR EXAMINATION AND TREATMENT

I hereby consent and authorize Morgan Family Medicine and all its providers and ancillary medical personnel to perform medical examinations and provide routine medical care for all my visits. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which my specific informed consent is not otherwise required. I understand that certain procedures will require specific informed consent and that MFM will provide me with information and forms prior to such procedures.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of Morgan Family Medicine's Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI") as well as clinic specific polices. I understand that MFM has the right to change its Notice of Privacy Practices and/or clinic specific policies from time to time and that whenever an important change is made, MFM will post a new notice in its office. I may contact MFM at any time to obtain a current copy of the Notice of Privacy Practices.

Signature: _____ Today's Date: _____

If applicable:
Representative's Name: _____ Relationship to Patient: _____

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Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

I, the above named patient, authorize Morgan Family Medicine to release and/or request my medical records to/from all healthcare facilities.

Information to be Disclosed: (Please check all boxes that apply)

- ◯ All Medical Records ◯ Lab Results ◯ ER Reports ◯ Imaging Reports
- ◯ Office/Progress Notes ◯ Initial Evaluation ◯ Discharge Summary ◯ Operative Reports
- ◯ Other: _____

These records may include:

- HIV/AIDs testing, test results, treatment and related information including high risk behaviors
- Drug and/or alcohol diagnosis, treatment, test results and reports, and referral information
- Mental health treatment, test results, reports including psychological and psychiatric studies

Requested Dates of Service:

- ◯ All dates of service
- ◯ 2 years prior from late date seen
- ◯ Specific Dates: _____ to _____

Reason for Disclosure:

- ◯ Continuation of Care
- ◯ Change of Insurance or Provider
- ◯ Other: _____

I understand that my signature is voluntary and if I refuse to sign this form it may result in the provider being unable to treat me fully without relevant medical history. I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. This authorization will expire one (1) year from the date signed.

Signature: _____ Today's Date: _____

(If applicable) Representative's Name: _____ Relationship to Patient: _____

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Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City & Zip Code: _____

Phone Number: _____ Email Address: _____

May we send you text messages? ◯ Yes ◯ No May we email you? ◯ Yes ◯ No

May we leave detailed messages at the phone number listed above? ◯ Yes ◯ No

Emergency Contact

Name: _____ Phone: _____ Relation: _____

I hereby authorize Morgan Family Medicine to release medical information (appointments, lab/imaging results, diagnoses, treatments, medications, surgeries, etc.) of the above-named patient via postal mail, telephone, fax, or email to the following individuals:

Name: _____ DOB: _____ Relation: _____ Phone: _____

Name: _____ DOB: _____ Relation: _____ Phone: _____

Name: _____ DOB: _____ Relation: _____ Phone: _____

Name: _____ DOB: _____ Relation: _____ Phone: _____

◯ *Do NOT disclose my information to anyone*

This authorization will expire one (1) year from the date signed.

Signature: _____ Relationship to Patient: Self Other (specify) _____

Printed Name of Representative: _____ Today's Date: _____