MORGAN FAMILY MEDICINE

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

Patient Name: _____ Preferred Name: _____

Address: _____ DOB: _____

Phone Number: _____ Email: _____

Do we have your consent to: TEXT ☐ Yes ☐ No CALL ☐ Yes ☐ No EMAIL ☐ Yes ☐ No

Marial Status Single ☐ Married ☐ Divorced ☐ Widow ☐	Male ☐ Female ☐	Gender Identity:
Hispanic or Latino: Yes ☐ No ☐	Race:	

Emergency Contact Name:	Relation::	Phone:
To whom may we disclose your health information? Appointment times, test results, billing information, etc	Name:	Phone:

Primary Insurance	
Policy Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	
Relationship to Subscriber	

Secondary Insurance	
Policy Number	
Group Number	
Subscriber Name	
Subscriber Date of Birth	
Relationship to Subscriber	

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, front you. If your insurance company requests a refund of payments made, you will be responsible for the amount 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.

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 your insurance 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.

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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.

CHECK HERE IS PATIENT IS A MINOR OR NOT THEIR OWN GUARANTOR □

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 a specific informed consent, and that MFM will provide me with information and forms prior to such procedures.

CLINIC POLICIES AND PRACTICES

By INITIALLING 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 my name.

_____ I agree that Morgan Family Medicine may share medical information with the Idaho Data Exchange for medical data sharing

_____ I agree with Morgan Family Medicine's scheduling policy – I will attend all scheduled appointments, or I will cancel by providing 24-hour notice. I understand there is a $35 fee for all appointments tha I do not attend unless it is cancelled or rescheduled with 24+ hours' notice.

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: _____