Susan Layeux, M.D.
Beverly J. Yercheck, ANP-C
Janet Lukehart, FNP-C
Phone: 208-267-3655
Fax: 208-267-3757

BOUNDARY Community Clinics
a division of Boundary Community Hospital
boundarycommunityhospital.org/clinics

PATIENT INFORMATION

_____ _____ _____ _____ _____
Last Name First Name Middle Previous Last Name Date of Birth

Social Security #_____ Male/Female (Circle) Phone: _____ County: _____

_____ _____
Mailing Address City State Zip Code

_____ _____
Physical or Secondary Address City State Zip Code

Race (please check one)
_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or other Pacific Islander
_____ White/Caucasian
_____ Multi-Racial
_____ Other: _____
_____ Decline to Answer

Language (please check one)
_____ American Sign Language
_____ English
_____ French
_____ German
_____ Japanese
_____ Mandarin – Cantonese
_____ Mandarin – Chinese
_____ Russian
_____ Somali
_____ Spanish
_____ Vietnamese
_____ Other: _____

Do you consider yourself to be of Hispanic or Latino ethnicity? (please check one) _____ NO _____YES _____ Decline to answer

Marital Status (please check one)
_____ Single
_____ Married
_____ Divorced
_____ Widowed

Student Status (please circle one)
_____ Full time
_____ Part time
_____ Not a Student

Are you a veteran? _____No _____ Yes

Do you smoke? _____No _____ Yes

Primary Care Provider _____ Referring Provider _____

Contact Information
Home Phone _____ Cell Phone _____
Day Phone _____ E-mail Address _____
Alternate/Emergency Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____ Self-Pay _____
**Please provide insurance card(s) for photocopying

_____ _____ _____
Employer Employer Address Employer Phone Number

Preferred Pharmacy _____ Location _____ Phone _____

To the best of my knowledge, all of the above information is true and complete. I authorize payment of insurance benefits to be paid directly to Boundary Community Clinics and I understand that I am responsible for any health insurance deductible, co-payment and/or co-insurance and will make specific arrangements to pay balances not covered by insurance on a timely basis. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and collection costs. I grant permission to my providers to mutually exchange medical information as outlined in the privacy policy of this organization.

Signed _____ Date _____

PRIVACY NOTICE ACKNOWLEDGEMENT

As a patient of Boundary Community Clinics, I understand that under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA") I have certain rights to privacy regarding my protected health information. I have been informed of the posted location of the clinic's Notice of Privacy Practices and offered a copy of the notice. I understand that Boundary Community Clinics has the right to change the notice from time-to-time and that I may contact my physician's office at any time to request a current copy of the notice

I understand that I may request in writing that Boundary Community Clinics restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Boundary Community Clinics is not required to agree to my requested restrictions, but if restrictions are agreed to, then Boundary Community Clinics is bound to abide by such restrictions.

Patient Name (please print) _____

Patient Signature: _____

Relationship (If other than patient) _____

PATIENT COMMUNICATION AUTHORIZATION

I, _____, wish to be contacted in the following manner (check all that apply):

_____ Home Telephone Number: _____

_____ OK to leave message with detailed information

_____ Leave message with callback number only

_____ Work Telephone Number: _____

_____ OK to leave message with detailed information

_____ Leave message with callback number only

_____ Written Communication

_____ OK to mail to my home

_____ No restrictions necessary

I, _____, authorize Boundary Clinics to disclose information to:

Spouse _____ Phone Number: _____

Child _____ Phone Number: _____

Parent _____ Phone Number: _____

Caregiver/Other _____ Phone Number: _____

Additional Comments: _____

_____

_____.

Signed: _____ Date: _____

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HEALTH HISTORY QUESTIONNAIRE

Patient Name _____ E-mail _____
Date of Birth _____ Phone _____

Please list recent physicians involved in your health care and their location:

Provider	Location
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a history of the following conditions?

	Yes	No	Details
Diabetes	___	___	_____
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
High Cholesterol	___	___	_____
Cancer	___	___	_____
Chronic Pain	___	___	_____
Lung Disease	___	___	_____
Other	_____		_____

Please list past surgeries and the year performed:

Surgery	Year Performed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any preventive health care procedures:

Procedure	Yes	No	When? (Most recent)
Colonoscopy	___	___	_____
PAP	___	___	_____
Mammogram	___	___	_____
Bone Density Scan	___	___	_____

Please list medications you are currently taking including supplements and herbs:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy_____

Please list any allergies:

_____

_____

_____

Please tell us about yourself:

Marital Status (please circle) Single/Divorced Married Widowed

Children (age) _____

Occupation (past, present or disabled) _____

Smoking (packs per day and number of years) _____

Alcohol (number of drinks per day) _____

Illicit Drug Use (present and past) _____

Family History:

Health Problem	Relation to you, age of family member and cause of death (if deceased)
Cancer	_____
Heart Disease	_____
Stroke	_____
Diabetes	_____
High Blood Pressure	_____
Mental Illness	_____
Other	_____

Review of Systems (Circle all that apply)

CONSTITUTIONAL	CARDIAC	METABOLIC	SKIN
Fatigue	Chest pain or pressure	Intolerance to heat	Rashes
Fevers	Racing or irregular heartbeat	Intolerance to cold	Itching
Night sweats	Leg pain when walking	Excessive thirst	Breast lumps
		Excessive hunger	

EYES	GASTROINTESTINAL	NEUROLOGIC	MUSCULOSKELETAL
Discharge	Abdominal pain	Memory loss	Joint pain
Vision loss	Constipation	Abnormal gait	Muscle weakness
	Diarrhea	Dizziness	Cramping
	Vomiting	Headaches	
		Seizures	

EAR, NOSE & THROAT	HEMATOLOGIC/LYMPHATIC	GENITOURINARY	RESPIRATORY
Hearing loss	Easy bruising	Pain with urination	Shortness of breath
Ear drainage	Easy bleeding	Blood in urine	Wheezing
Nasal drainage		Penile or vaginal discharge	
		Excessive urination	

PSYCHIATRIC	IMMUNOLOGIC
Depression	Seasonal allergies
Anxiety	Food allergies

This form will be reviewed by the physician you have selected prior to acceptance as a new patient and prior to an appointment being scheduled.

I release the enclosed information to Boundary Community Clinics. In the event I am not accepted as a patient, I understand this information will be destroyed. If I am accepted as a patient, this information will be stored in my chart.

Patient Signature_____ Date _____

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Prescription Policy

Boundary Community Clinics requires a minimum of two (2) business days to respond to prescription refill requests.

- Notify your pharmacy that you are in need of a refill. The pharmacy will submit the refill request to your physician and your physician will return the refill authorization to the pharmacy within 48 hours. Please check with your pharmacy regarding the status of your refill.

- If there are no refills left on the prescription, please notify your pharmacy. The pharmacy will submit the refill request to your physician. If the physician elects to refill the prescription, he/she will return the refill authorization to the pharmacy within 48 hours. Should the physician wish to see you prior to authorizing a refill, the office will contact you within 48 hours to schedule an appointment.

- If you need a written prescription for your pharmacy or for mailing purposes, please inform Boundary Community Clinics' office staff.

Patient No Show Policy

Boundary Community Clinics requires 24 hour notice of appointment cancellation. Failure to notify the office of two or more cancellations will result in a $25.00 fee. This fee cannot be billed to your insurance carrier and you will be responsible for the payment.

If you are continually unable to notify the office of a cancellation in a timely manner, we may be unable to continue to provide services to you.

I have read and understand the above information.

_____
Signature of Patient or Guardian
Date_____

Portal Access Consent & Agreement

- I have been provided information about the NextGen Patient Portal for the Boundary Community Clinics.
- I understand that my personal health and individually identifying information is available to me via the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information. To permit this access, a specific request will need to be made through the medical records department.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use at the time of sign-up.
- If I refuse to accept the Portal at this time, I understand that I may change that decision in the future and can contact the Boundary Community Clinics to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

☐ I want to access the Portal to view my medical records.

My e-mail address is: _____

☐ No private e-mail available at this time. I may be interested in the future. Please ask me again.
☐ I am refusing the option of accessing my medical records via the Portal.

Patient Signature: _____ Date: _____ Time: _____

Clinic Staff Signature: _____ Date: _____ Time: _____

Patient Name:_____
DOB:_____/_____/_____

Consent for Treatment

HEALTH AND MEDICAL CARE CONSENT: I give my consent to all healthcare services performed by Boundary Community Clinics, its employees, agents and affiliates, to provide such medical care (including evaluation, diagnostic procedures, and medical treatment) as may be deemed necessary and appropriate by my attending physician or surgeon, his/her assistant, or his/her designees. Boundary Community Clinics conducts training programs for healthcare professionals. These persons may be observing or participating in Boundary Community Clinics' treatment programs. They will be under the direct supervision of licensed professionals. I understand that I have the right at any time to refuse to have trainers participate in my care.

RELEASE OF INFORMATION AND INSURANCE BENEFITS: I authorize Boundary Community Clinics and my physician to release my medical and/or financial records to individuals and entities as specified in the Notice of Privacy Practices and/or by Federal and State Law. I understand that Boundary Community Clinics may also release medical information about me to physicians or other healthcare providers who may be involved in my continued care. I understand that this authorization will remain in effect for 12 months unless I revoke it, in writing. I understand that any revocation will not be effective for disclosures necessary to determine and obtain payments for healthcare that has been provided.

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY: I authorize and assign direct payment of insurance benefits to Boundary Community Clinics and providers involved in my care for all amounts due from my primary and/or supplemental insurance carrier(s). I understand and agree that I am financially responsible for payment of any charges which insurance does not pay. I further understand, lacking timely payment by my insurance, I will be required to assume responsibility for payment of my account. If financial assistance is requested for payment of my account, I give my permission for investigation of my credit including consumer reports. I understand that services are provided to me, the patient, and not my insurance company. I understand and agree that I am responsible for payment of all Boundary Community Clinics' charges and the fees of other professional providers for care rendered to me at Boundary Community Clinics. By signing below, I consent to be contacted by regular mail, by email, or by telephone (including a cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide. If my bill is not paid in full, I agree to be responsible for all reasonable attorney fees and court costs in collecting any sums due and owing for services received.

ACKNOWLEDGEMENTS (PATIENTS TO INITIAL EACH ACKNOWLEDGEMENT, IF APPLICABLE):

- I acknowledge the receipt of the **Notice of Privacy Practices**
- I acknowledge receipt of the **Patient Bill of Rights and Responsibilities**
- I provided my **Ethnicity, Race and What Language I Prefer** to receive medical and healthcare instructions

I have read this form and understand its contents. I have had an opportunity to ask questions, which have been answered to my satisfaction.

_____
Print Name

_____ _____
Patient Signature Date/Time

_____ _____
Signature of authorized Representative/Parent Guardian Date/Time

_____ _____
Signature of Witness Date/Time

Request that Medical Records from Another Healthcare Provider be sent to Boundary Community Clinics

Please print clearly, otherwise your request may be revoked or delayed.

For the Patient(s) identified in the list below: I_____ (name);
Address and Phone: _____ authorize

Name of Healthcare
Provider or Facility: _____
Complete Address: _____
_____
Phone and Fax: _____

to release the standard set of medical records (immunization record, medication list, problem list, most recent well visit physical exam, consultant notes, lab work, radiology and other information important to the patient's ongoing care) to:

Boundary Community Clinics
6641 Kaniksu Street
Bonners Ferry, ID 83805

Phone: (208) 267-3655
Fax: (208) 267-3757

Patient Name	Date of Birth	Dates of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

Purpose of Request: ☐ Personal Use ☐ Transfer of Care ☐ Other

As the person signing this authorization, I understand that I am giving my permission to the disclosure of confidential healthcare records to include, if applicable, Psychiatric, Drug/Alcohol or HIV Testing/Treatment records and other information contained in the medical record, unless otherwise indicated under my special instructions written below.

I understand that I have the right to revoke this authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that my revocation may not be effective if I lack the capacity to sign the revocation, if a licensed provider determines that the revocation is reasonably likely to cause serious harm to me or other persons, or when the revocation is not permitted by law.

If you prefer the entire record, instead of the standard record release described above, please initial: _____

Special Instructions (none if blank): _____
_____.

This authorization is only valid for the information/purpose indicated above and expires 180 days (6 months) from signature date unless otherwise indicated on this authorization.

X

_____ Date: _____
Signature of Patient or Legal Representative

If signing as Legal Representative, indicate relationship to patient:_____