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

General Patient Information

Patient Name: (Last, First, Middle)	**Date of Birth:**	**Gender:** ☐ Male ☐ Female	
Previous Last Name:	**Social Security Number:**		
Mailing Address:	**City & State:**	**Zip:**	**County:**
Physical/Secondary Address:	**City& State:**	**Zip:**	**County:**

Home Phone:	**Work Phone:**	**Mobile/Cell Phone:**	**Email:**

Marital Status: ☐ Single/Divorced ☐ Married ☐ Widowed	**Race:** ☐ 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:** ☐ American Sign Language ☐ English ☐ French ☐ German ☐ Japanese ☐ Mandarin (Cantonese or Chinese) ☐ Russian ☐ Somali ☐ Spanish ☐ Vietnamese ☐ Other: _____

Employment Status: ☐ Employed ☐ Disabled ☐ Retired	**Do you consider yourself?** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer	**Student Status:** ☐ Full-Time ☐ Part-Time ☐ Not a Student	**Veteran Status:** **Are you a Veteran?** ☐ No ☐ Yes – If yes, which branch? **Branch:** _____

Employer:	**Occupation:**		
Employer Address:	**City & State:**	**Zip:**	**County:**
Employer Phone:	**Employer Contact:**		

Emergency Contact Information

Emergency Contact:	**Second Emergency Contact:**
Relationship to Patient:	**Relationship to Patient:**
Home Phone:	**Home Phone:**
Mobile/Cell Phone:	**Mobile/Cell Phone:**

Insurance Information

I do not have Insurance:

☐ **I am a Self-Pay Patient**

☐ **I am interested in a discount for paying my complete balance at the time of service.**

☐ **I am interested in applying for Financial Assistance because I don't have insurance and/or qualify for Medicaid.**

Primary Insurance:			**Name of Insured:**
Address:			**Subscriber ID:**
City:	**State:**	**Zip:**	**Group Number:**
Phone Number:			

Secondary Insurance:			**Name of Insured:**
Address:			**Subscriber ID:**
City:	**State:**	**Zip:**	**Group Number:**
Phone Number:			

To the best of my knowledge, all of the information provided on these documents are 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 willmake 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 mutuallyexchange medical information as outlined in the privacy policy of this organization.

I have read and understand the above information.

Patient Name (Print):	**Patient Date of Birth:**
Signature of Patient or Guardian:	**Date:**

HEALTH HISTORY QUESTIONNAIRE

Medical History – Check if you have ever had or do have any of the following, and year of onset			
Condition	**Year Diagnosed**	**Condition**	**Year Diagnosed**
☐ Allergies – What kind? _____		☐ Diabetes-Type 1 or 2 _____	
☐ Anxiety		☐ Heart Attack	
☐ Arthritis		☐ High Cholesterol	
☐ Asthma		☐ High Blood Pressure	
☐ Blood Clots – Where? _____		☐ Osteoporosis	
☐ Cancer – What Type? _____		☐ Renal Disease – Stage? _____	
☐ Coronary Artery Disease		☐ Stroke	
☐ COPD		☐ Thyroid Disorder	
☐ Chron's Disease		☐ Other:	
☐ Depression		☐ Other:	

Surgical History – Check if you have received the following procedures, and year performed					
☐ None					
Surgical Procedure	**Year Completed**	**Surgical Outcome**	**Surgical Procedure**	**Year Completed**	**Surgical Outcome**
☐ Appendectomy			**Female Only**		
☐ Back Surgery			☐ Breast Biopsy		
☐ Heart Surgery			☐ Cesarean Section		
Type:			☐ Mastectomy		
☐ Hernia Repair			Cancerous:		
Type:			☐ Hysterectomy		
☐ Knee Surgery			Cancerous:		
Type:			**If Hysterectomy – what kind?**		
☐ Tonsillectomy			☐ Total		☐ Vaginal
Other:			☐ Total, Removal of both tubes and ovaries		
Male Only			☐ Total. Unilateral of tube and ovary		
☐ Vasectomy			☐ Radical		

Family History

Are you adopted? ☐ **Yes** ☐ **No**

Relationship to you	No Known Problems	Addiction	Alzheimers / Dementia	Aneurysm / AAA	Anxiety / Depression	Asthma	Cardiac issues	COPD	Diabetes	Hyperlipidemia	Hypertension	Kidney/Renal Disease	Mental Illness	Stroke	Thyroid Disorder	Cancer- List type and age diagnosed below	Deceased? Write Cause of Death and age at time of death below
Mother Age, if alive																	
Father Age, if alive																	
Sister Age, if alive																	
Brother Age, if alive																	
MGM Age, if alive																	
MGF Age, if alive																	
PGM Age, if alive																	
PGF Age, if alive																	

Social History

Do you have any children? ☐ Yes ☐ No If yes, How many: Male(s)_____ Female(s)_____

Who do you live with? ☐ Spouse ☐ Child ☐ Caregiver ☐ Other ☐ Pet If yes, What kind of pet(s): _____

Do you have a support network to assist you if necessary: ☐ Yes ☐ No If yes, Who? _____

How often do you get together with friends and/or relatives? ____ times per ☐ Week ☐ Month ☐ Year ☐ Never

How difficult is it for you to obtain very basics, like food, housing, heating, and medical care?

☐ Very Difficult ☐ Difficult ☐ Somewhat Difficult ☐ Not Difficult

Do you have stable/permanent housing: ☐ Yes ☐ No Do you have smoke detectors in your home: ☐ Yes ☐ No

Do you have Carbon Monoxide Detectors in your home: ☐ Yes ☐ No

What is your heat source: ☐ Coal ☐ Electric ☐ Gas ☐ Oil ☐ Propane ☐ Solar ☐ Wood ☐ Other: _____

Do you use your seatbelt when in a vehicle? ☐ Yes ☐ No

Have you experienced changes in sleep patterns: ☐ Yes ☐ N0 If yes, How _____

Number of hours of sleep per night: _____

What is your Activity Level: ☐ Moderate ☐ Sedentary ☐ Vigorous Are you a Member of a Health Club: ☐ Yes ☐ No

Do you exercise: ☐ Yes ☐ No (Never) If yes, How frequent: ☐ Daily ☐ Occasional ☐ 2-3 times/week ☐ 3-4 times/week

What type of exercise do you do? _____

Do you use tobacco products? ☐ Yes ☐ No If yes, age started: _____ If former, age quit: _____

If yes, or if former user, what kind and how often?

☐ Cigarettes - ____packs/day ☐ Chew-_____cans/day ☐ Cigars-_____/day ☐ E-Cigs-_____/day ☐ Pipe

Have you been, or are you currently exposed to second hand smoke? ☐ Yes ☐ No

What kind? _____ For how long have you been/were you exposed? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, How much? ____ If yes, what type? ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drinks

Do you drink alcohol? ☐ Yes ☐ No If yes, How much? _____ ☐ Day ☐ Week ☐ Month

When was your last drink? _____ What Kind? _____

Have you / do you use recreational or street drugs? ☐ Yes ☐ No ☐ Previously

If yes, what kind: ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Opioids ☐ Speed ☐ Methamphetamine ☐ Other: _____

Patient Name (Print):	**Patient Date of Birth:**
Signature of Patient or Guardian:	**Date:**

PRIVACY NOTICE ACKNOWLEDGEMENT

As a patient of Boundary Community Clinics, I understand that under the Health Insurance Portability & Accountability Actof 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 Clinicshas 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 currentcopy 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. I understand this "Release of Information" will remain in effect until terminated by me in writing.

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:_____

Signature of Patient or Guardian:	**Date:**
Signature of Witness:	**Date:**

Care Teams

Please list the physicians involved in your health care and their location, including Specialists:

Provider	Location	Phone Number

Prescriptions, Supplements, & Herbs

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

Preferred Pharmacy_____Location_____Phone _____

Name	Dose	Frequency	Time
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM
_____	_____	_____	☐ AM ☐ PM

These documents will be reviewed by the provider 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 willbe destroyed. If I am accepted as a patient, this information will be stored in my chart.

Patient Name (Print): _____ Date of Birth: _____

Signature of Patient or Guardian: _____ Date: _____

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.

Appointment Cancellation and "No Show" Policy

Boundary Community Clinics requires 24-hour notice of appointment cancellation. Failure to notify the office of cancellation prior to 24 hours will result in a @25.00 fee. Arriving late to your appointment is considered a "No Show" appointment, and will also result in a $25.00 fee. These fees are unbillable to your insurance carrier, making the payment of the charge the patient's responsibility.

If you are continually unable to notify the office of a cancellation in a timely manner, or have repetitive "No Show" appointments, we may be unable continue to provide services to you.

I have read and understand the above information.

_____

Signature of Patient or Guardian

Date_____

Patient Name:_____

DOB:____/_____/_____

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 safeguardingmy access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communicationsrelated 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 thetime 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 cancontact 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 thePortal.

☐ 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.

Signature of Patient or Guardian:_____ **Date:**_____

Clinic Staff Signature:_____ **Date:**_____

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 determineand 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 insurancecarrier(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 consumerreports. I understand that services are provided to me, the patient, and not my insurance company. I understand and agree that I amresponsible 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 tobe 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**

_____ _____

Signature of Authorized Representative/Parent /Guardian **Date**

_____ _____

Signature of Witness **Date**

BOUNDARY Community Clinics
a division of Boundary Community Hospital

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.

Patient Name: _____ Date of Birth: _____

Signature of Patient/Legal Guardian: _____ Date: _____