BOUNDARY Community Clinics
a division of Boundary Community Hospital

Legal Name:		**Date of Birth:**	**Gender:**
Preferred Name:		**Social Security Number:**	**Marital Status:**
Mailing Address:		**City, State, Zip:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Email Address:			
Preferred Pharmacy/Location:		**May we access your prescription History? _YES _NO**	
What is your Race?		**_____Hispanic**	**____Not Hispanic**
What is the best way to contact you? __Phone __Mail __Email **Does your phone have secured voicemail for messages? __ YES __NO** **How did you hear about us? __ Friend __ Social Media __ Other:_____**			
Patients Employer:	**Occupation:**	**Employer Phone:**	
Emergency Contact/Guardian: (Name Last,First)	**Phone:**	**Relationship:**	
Guarantor/Guardian: Name (Last,First)		**Relationship to Patient:**	
DOB:	**Social Security Number:**	**Phone:**	

PRIMARY INSURANCE:		**SECONDARY INSURANCE:**	
Policy Holder:		**Policy Holder**	
Insured DOB:	**SSN:**	**Insured DOB:**	**SSN:**
Group#	**Policy#**	**Group#**	**Policy#**
Relationship to Patient:		**Relationship to Patient:**	

CONSENTS/POLICIES

Health and Medical Care Consent: The Undersigned here by consent to any Medical, Surgical, Anesthetic, Laboratory Medication, and or X-Ray procedures which the physician/allied health professional may order. It is understood that the patient is under the direction of the attending physician/allied professional and the clinic is not liable for any act or omission on the part of the physician/allied health professional.

Notice of Privacy Practices: Boundary Community Clinics notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting it. A copy will be supplied upon request. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations and acknowledge receipt of the Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Rights: Every patient has rights and responsibilities. By signing this form you agree you have been advised of your rights as a patient. A copy can be provided to you on request.

Release of Information and Assignment of Insurance Benefits: Boundary Community Clinics may disclose all or part of the patient's medical or financial records to any person or corporation which may be liable under contract to the clinic including, but not limited to the patient, insurance carriers, or Welfare Funds. In the event the patient is entitled to clinic benefits of any type arising out of any policy or insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to the clinic for application to the patient's bill. Then undersigned also gives the clinic and/or their representative permission to initiate a claim, on behalf of the patient, to any entity, person, or business that may be responsible for payment of services rendered.

Prescription Policy: Boundary Community Clinics requires a minimum of 2 business days to respond to prescription refill requests. Notify your pharmacy, the pharmacy will submit the request to the clinic.

Appointment Cancellation and No Show Policy: Boundary Community Clinics requires a 24 Hour notice of appointment cancellation. Failure to notify the clinic within 24 hours will result in a $25.00 fee.

Portal Access Consent and Agreement: I would like Patient portal access ____
I refuse Patient Portal Access ____

Consent: To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me. I am willing to make specific arrangements to pay any part not covered by insurance on a timely basis. A photocopy of authorized Medicare benefits is made directly to the practice for any service provided me by the practice's providers. **I understand this consent is effective for 1 year.**

Patient signature: _____ **Date:** _____

Signature of parent or guardian: _____ **Date:** _____

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 identified: I_____(name);

Address and Phone:_____authorize

Physician/Provider/Facility _____

Address _____

Phone Number _____

Fax Number _____

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 alicensed 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: _____**

HEALTH HISTORY QUESTIONNAIRE

Please List recent physicians involved in your health care and their location, including specialists.

Provider	Location/Phone Number

Please list any medications you are currently taking including prescription and over the counter.

Name	Dose	Frequency

Please list any allergies/reaction: _____

_____

_____

This form will be reviewed by the physician. I release the enclosed information to Boundary community Clinics.

Patient Name (printed): _____

Patient Signature: _____

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		

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																	
Sister Age, if alive																	
Brother Age, if alive																	
Brother Age, if alive																	

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? _____ How long have you been/were you exposed?_____

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

When was your last drink? _____ What Kind? _____

Do you drink caffeine? □ Yes □ No If yes, How much? ____ If yes, what type?

□ Coffee □ Tea □ Soda □ Energy Drinks

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

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

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/ relatives? ____ times □ 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

Have you experienced changes in sleep patterns: □ Yes □ No If yes, How _____

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 week □ 3-4 week

What type of exercise do you do? _____

Do you have spiritual beliefs: □ Yes □ No Would they impact medical care? □ 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

Patient Name (Print):_____ DOB: _____

Signature of Patient/Guardian: _____

Informed Consent for Telehealth and Telephonic Services

- I understand that telehealth and telephonic services are the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the telehealth and/or telephonic visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and/or see the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telehealth and telephonic services.
- I understand that I will be responsible for any copayments or coinsurances that apply to my telehealth or telephonic visit.
- I understand that I have the right to withhold or withdraw my consent to the use of telehealth or telephonic services in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that by giving verbal consent I am agreeing to receive health care services via telehealth and telephone, and I will sign and return this consent form.
- I understand that by signing this form that I am consenting to receive health care services via telehealth and telephonic services.
- My provider has discussed the risks and benefits of telehealth services with me.
- I agree to remain in my county of permanent residence when receiving telehealth and telephonic services.

☐ All above information has been reviewed with the patient, and verbal consent obtained at time of visit.

I DECLINE TELEHEALTH SERVICES AT THIS TIME INITIAL _____

PHONE NUMBER _____

EMAIL ADDRESS _____

_____
Client Name

_____ _____
Client Signature Date

_____
Provider Name/Credentials

_____ _____
Provider Signature Date

PRIVACY NOTICE ACKNOWLEDGEMENT

As a patient of Boundary Community Clinics, I understand 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 the 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 my 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 COMMUNICATION AUTHORIZATION

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY)

Current Home/Cell Telephone # _____

____ OK to leave a message
____ Leave a callback number only
____ Ok to mail to my home

I AUTHORIZE BOUNDARY COMMUNITY CLINICS TO DISCLOSE INFORMATION TO AND COMMUNICATE WITH:

Any healthcare provider yes no

List authorized individuals:

Name	Relationship	Phone Number

Patient Name (PRINT): _____

Patient Signature: _____Date: _____

Annual Privacy Review Acknowledgement

Patient Initials: _____ Date Reviewed & Revised: _____
Patient Initials: _____ Date Reviewed & Revised: _____
Patient Initials: _____ Date Reviewed & Revised: _____