LifeStages

Family Practice OB/GYN

3908 E Flamingo Ave
Nampa, ID 83687
(208)442-8035

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Date:_____Time:_____ Please Print

*******PATIENT*******

LAST NAME_____FIRST NAME_____MI_____

DATE OF BIRTH_____SOCIAL SECURITY #_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE_____CELL_____ WK PHONE_____

EMPLOYER_____ **May we contact you at work? Yes ☐ No ☐**

*******SPOUSE OR GUARDIAN:**********

NAME_____BIRTHDATE_____

SOCIAL SECURITY_____EMPLOYER_____WORK PHONE_____

*********PRIMARY INSURANCE COVERAGE*******

COMPANY NAME_____COPAY $_____

SUBSCRIBER NAME_____REL. TO PATIENT_____

SUBSCRIBER SOC SEC #_____ DATE OF BIRTH_____

POLICY #_____GROUP#_____

*********SECONDARY INSURANCE COVERAGE*******

COMPANY NAME_____COPAY $_____

SUBSCRIBER NAME_____REL. TO PATIENT_____

POLICY #_____GROUP#_____

IN CASE OF EMERGENCY, WHOM CAN WE CONTACT?
(Someone other than spouse or guardian)
NAME_____REL._____PHONE_____

*Whom shall we thank for referring you?*_____

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

Guarantor Signature_____ ***Date***_____

**********TURN OVER PLEASE**********

L I F E S T A G E S
3 9 0 8 E F l a m i n g o A v e
N a m p a , I D 8 3 6 8 7

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that LIFESTAGES has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

Patient Name _____

Relationship to Patient _____

Signature_____

Date_____

OFFICE USE ONLY
I attempted to obtain the patients signature in acknowledgement on this notice of Privacy Practice Acknowledgement. But was unable to do so as documented below.

DATE: INITIALS:

REASONS:

_____

_____

_____

LIFESTAGES

Dear Patient,

It is our policy to keep all matters regarding our patient's in strict confidence. Please take a few moments of your time to provide us with the names of your family and/or friends who may call for information regarding your test or any other medical information.

Persons I authorize to obtain information for me:

_____

_____

_____

Patient or Guardian
Signature _____

Date_____

Reviewed:

Date_____Signature_____

Date_____Signature_____

Date_____Signature_____

Date_____Signature_____

Date_____Signature_____

L I F E S T A G E S
3 9 0 8 E F l a m i n g o A v e
N a m p a , I D 8 3 6 8 7

Clinic Policies

We would like to take this opportunity to welcome you to LIFESTAGES. Your clear understanding of our policies is important to our relationship. Therefore please read carefully and feel free to ask any questions you may have. Our office hours are:

Monday-Thursday 8:30-5 Friday 8:30 - 12

If you have an emergency after hours that cannot wait until normal business hours, please call (208) 442-8035 and an operator will page the doctor on call. Otherwise please hold non-emergent matters until regular office hours.

Please initial after reading each policy – regardless of applicability.

_____Refill Requests- please **give 24 hours notice on all refills**.
Contact your pharmacy, and they will contact us with your needs. Refills will be authorized Monday thru Friday only, and only during regular office hours. Narcotics (controlled medications) will not be filled after clinic hours, and can only be filled by your primary physician. Please do not wait until you are completely out before calling.
_____Appointments – **please give 24 hours notice if you are unable to make your scheduled appointment with your doctor.** We understand that circumstances arise when you are unable to do so, but we ask that you provide us adequate notice to fill your appointment time with patients who may need medical attention.

Financial Policies

_____ Monthly payments are required and balances need to be paid within 90 days of receiving your first statement. Unpaid balances will be reviewed and sent to Bonneville Management Service for payment arrangements or Bonneville Collections which ever applies.
_____We will be happy to file your insurance claims for you. However we do request a copy of your current insurance card to ensure accurate billing. Please keep in mind: we do not accept all insurances. It is your responsibility to confirm directly with your insurance company to find out whether or not we participate with them and if they will cover the medical services being provided to you. If your insurance requires a referral, co-pay or deductible, it is your responsibility to have it with you at the time of service. Failure to do so may result in rescheduling your appointment.
_____A Parent or Guardian must accompany minors at the first new patient visit, afterward; we will accept a written note by the responsible party.
_____All NEW patients are required to pay for deductibles and co-pays at time of service. **All Private Pay** patients (no insurance) will be required to pay in full at the time of service. For your convenience, our office staff can give an estimate of charges for your appointment ahead of time, but these quotes are not exact.
_____Medicare only pays for routine physicals every two years. Please be aware that you may be billed for your exam if denied by Medicare.
_____As a courtesy, we will bill your insurance for you. However, it is your responsibility to follow up with your carrier if the claims are not paid. Our billing staff will be happy to assist you, please contact them for any questions. If payment is not received by the insurance with in 60 days, the balance will be transferred to patient responsibility.
_____All returned checks will be subject to a $20 charge.
_____Birth Control/Fertility – Due to the majority of Insurance carriers not covering contraceptive management, payment is **due in full** at time of any service relating to Birth Control/Infertility. (IUD, Diaphragm fitting, Depo-Provera Injection etc…)
_____ **Effective Jan 1, 2017** our office will complete **ONE** set of FMLA/Short Term Disability forms, any set thereafter you will be charged $25 to be paid before completion of forms.

********** TURN OVER PLEASE **********

Surgery

_____All surgeries will be pre-certified prior to admission and the insurance company will quote benefits. **Your Co-insurance percentage is required 5 days prior to admission.** The remaining balance will be set up on a monthly payment plan to be paid off no later than 3 months from the surgery date.

_____Patients with NO Insurance and needing surgery are required to pay half of the total surgery amount 2 days prior to surgery. The remaining balance will be set up on a payment plan or with Bonneville Management Service

_____If our office does not receive the down payment by the deadline your surgery may be postponed until payment is made.

Medicaid Financial Policies **please check if not applicable ☐**

Please initial after reading each policy – regardless of applicability

_____Medicaid patients on the Healthy Connections Program must be responsible for arranging for referrals ahead of the appointment time.

_____ Our office will not back-bill any laboratory fees for patients with Medicaid approvals provided after the date of service. You will be responsible for those fees.

_____You are required to bring your medical card for every visit. If your card is not available for the visit, we may ask you to reschedule your visit.

_____Fertility – due to Medicaid not covering family planning services, payment is due in full at time of any service relating to this.

I understand that I am responsible for all charges regardless of insurance coverage, and I have read and understand the financial policies of LifeStages.

I request that payment of authorized insurance benefits be made, on my behalf, to LifeStages for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Council on Medical Service and its agents any information needed to determine benefits or the benefits payable for related services. This authorization is in effect until I choose to revoke it.

I understand that I am responsible for all charges regardless of insurance coverage, and I have read and understand the financial policies of LIFESTAGES.

Patient or Guardian Signature_____Date_____

LIFESTAGES

History and Physical

Name_____DOB_____

Chief Complaint_____

Medical History	you	family	Comments/Details
Cardiovascular disease	☐	☐	_____
Hypertension	☐	☐	_____
Headaches	☐	☐	_____
Head/Ear/Neck/Throat	☐	☐	_____
Respiratory Problems	☐	☐	_____
Breast Disease	☐	☐	_____
Jaundice/Hepatitis	☐	☐	_____
Gall Bladder Disease	☐	☐	_____
Bowel disorders	☐	☐	_____
Kidney Problems	☐	☐	_____
Urinary Tract Infections	☐	☐	_____
Anemia/Blood disorders	☐	☐	_____
Blood Transfusions	☐	☐	_____
Osteoporosis	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid Disease	☐	☐	_____
Cancer	☐	☐	_____
Dementia/Neuro disorders	☐	☐	_____
Alcohol/Drug Problems	☐	☐	_____

Obstetrical History

Number of Pregnancies_____Births_____

Menstrual History

Date of Last Period_____Prior Period_____

Current Contraception_____

Date of last Pap_____

(Please check if any apply)

☐vaginal dryness ☐itching ☐painful intercourse

☐burning ☐other_____

Hospitalization or Surgeries

Illness/operation	Date
_____	_____
_____	_____
_____	_____

Medications

_____

_____

_____

Allergies

_____

_____

_____

For physician use

Lifestages
FAMILY PRACTICE OB/GYN

Patient Name: _____ Date: _____

Due to new reporting requirements by the government and for our new electronic medical record, we need these additional questions answered from our patients:

Race:

□ American Indian or Alaskan Native

□ Asian

□ Native Hawaiian or Other Pacific Islander

□ Black or African American

□ White

□ Hispanic

□ Other Pacific Islander

□ Other Race

□ Unreported or refused to report

Ethnicity:
□ Hispanic or Latino □ **Not** Hispanic or Latino

□ Refused to report

Language:
□ English □ Indian (Includes Hindi & Tamil) □ Russian

□ Other □ Spanish

Pharmacy of choice: Please list city and street of pharmacy

1. _____
2. _____

Email: _____