# LifeStages

Family Practice OB/GYN

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

Dustan T. Hughes M.D. ☐
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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_____

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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**
**3908 E Flamingo Ave**
**Nampa, ID 83687**

## Obstetrics financial Policies

Please initial after reading each policy

_____Our OB package does not include labs, ultrasounds, or hospital visits. It does include your visits with your doctor and the delivery of your baby, as well as your post partum visits. This package cannot be billed to your insurance until after delivery, so charges will be posted to your account, and will be a part of your monthly statements. Also, please remember this is an ***estimate*** and we ***cannot*** guarantee how your insurance will process claims.

_____Any complication or risk such as cesarean section or multiple births will change the amount of the package.

_____You will be billed for the services performed by the facility separately. You will need to contact them for admission planning and payment arrangements.

IF YOU HAVE INSURANCE

_____At your first prenatal visit, your insurance will be notified of your pregnancy, and at the same time, we will get an estimate of your "out-of-pocket" amount for your package (assuming you will have a normal delivery). We will require your down payment of $100 to be paid at that first visit. The remainder of your portion will be arranged in monthly payments and be paid in full the month prior to your delivery.

HIGH DEDUCTIBLE/NO INSURANCE

_____At your first prenatal visit, you will be expected to bring in $350 as your down payment for your prenatal care. We will set up a monthly payment plan that will have your balance paid one month prior to your delivery.

I understand I am responsible for these charges regardless of insurance coverage and I have read and understand the obstetric financial policy 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:** _____

Patient Name: _____ Date: _____

## Do you have a ***FAMILY HISTORY*** of any of the following cancers?

## Please check box if Yes:

- ☐ Any Prostate, Colorectal, Uterine or Endometrial Cancer under 51 y/o
- ☐ Any Female Breast Cancer under 46 y/o
- ☐ Ovarian Cancer (any age)
- ☐ Pancreatic Cancer (any age)
- ☐ Male Breast Cancer (any age)
- ☐ Abnormal Tumor Screening results or Ashkenazi Jewish ancestry
- ☐ 2+Any Cancers in the same family member (any age)
- ☐ 3+Any Cancers on the same side of family (maternal or paternal)
- ☐ Any known BRCA1/BRCA2 or other cancer susceptibility gene pathogenic mutations

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Patient or Guardian Signature_____Date_____

Lifestages
Family Practice OB/GYN

Juliette Hughes MD - Dustan Hughes MD - Janine Franco PA-C - Jocelyn Benton PA-C

# Missed Appointment Policy

To provide the highest quality care, it is necessary for patients to attend their scheduled appointments on time. As a courtesy, an appointment reminder may be sent prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time, regardless of prior notification. If you are unable to keep your appointment, please notify us as soon as possible. We understand that occasional missed appointments can occur for a variety of reasons.

A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before the scheduled time. There will be a charge for a missed or late -cancelled appointment of **$25.00**. **Insurance will not cover charges for missed or late cancellation fees.**

An appointment is considered missed when any of the following occur:

- The appointment is cancelled within 24 hours of the scheduled meeting time
- The patient does not present to the office for the scheduled appointment
- The patient arrives more than 10 minutes late

After each missed appointment, you will receive a phone call from our administrative staff. After the third missed appointment within a one-year time period, we reserve the right to remove you from our schedule at which point your account will be reviewed by your provider.

I have read and understand Lifestages Missed Appointment Policy and understand that it is my responsibility to plan and attend appointments according to the schedule that I have created with my provider. Furthermore, I understand that it is my responsibility to give at least 24-hour advanced notice to Lifestages if I cannot attend my scheduled appointment or I will be charged a fee of $25.00 for a No Show or Late Cancellation.

_____ _____ _____

Patient Name Date of Birth Date

_____ _____

Patient signature or Parent/Guardian if minor Relationship to Patient

_____ _____

Lifestages Staff Signature Date

3908 E. Flamingo Ave Nampa Idaho 83687 Phone (208) 442-8035 Fax (208) 442-8038