# LifeStages

Family Practice OB/GYN

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

Dustan T. Hughes M.D.
Juliette E. Hughes M.D.
Jocelyn Benton PA-C
Joanne Adams DNP, NP-C

*****PATIENT*****

LAST NAME_____ FIRST NAME_____ MI_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

ADDRESS_____ LINE 2_____

CITY_____ STATE_____ ZIP_____

PRIMARY PHONE #_____ BACK UP # (if applicable) _____

EMPLOYER_____

*****SPOUSE OR PARENT/GUARDIAN*****

FULL NAME_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____

PHONE NUMBER_____ EMPLOYER_____

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

***PLEASE COMPLETE EVEN IF WE HAVE TAKEN A COPY OF YOUR CARD***

☐Check here for No Insurance/Self Pay

INSURANCE NAME_____ COPAY $_____

SUBSCRIBER NAME_____ DATE OF BIRTH_____

SUBSCRIBER SOCIAL SEC #_____ REL TO PATIENT_____

ID/POLICY #_____ GROUP #_____

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

INSURANCE NAME_____ COPAY $_____

SUBSCRIBER NAME_____ DATE OF BIRTH_____

SUBSCRIBER SOCIAL SEC #_____ REL TO PATIENT_____

ID/POLICY #_____ GROUP #_____

IN CASE OF EMERGENCY WHOM SHOULD WE CONTACT? ☐Check here for Spouse/Guardian named above

NAME_____ REL._____ PHONE_____

*I authorize this office to release to the name 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*_____

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Due to reporting requirements by the government and for our 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
- ☐ Other Race:_____
- ☐ Decline to Specify

**Ethnicity**

- ☐ Hispanic or Latino
- ☐ **NOT** Hispanic or Latino
- ☐ Decline to Specify

**Language**

- ☐ English
- ☐ Spanish
- ☐ Other:_____

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**Pharmacy of choice:** Please list the street and city of preferred pharmacy to ensure prescriptions are sent to correct location

Primary_____

Secondary_____

**Would you like to be web-enabled in our system?** This will allow you to view lab results, balances accrued, receive appointment reminders, and access your medical records through our clinic's patient portal

☐Yes ☐No

If Yes, email address:_____
(This address will serve as your username for the portal, and be used for related correspondence)

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# PEDIATRIC HISTORY AND PHYSICAL

Patient's Name_____DOB_____

Is the child yours by ☐Birth ☐Adoption ☐Stepchild

Child's parents are ☐Married ☐Unmarried ☐Divorced ☐Separated

***For newborns:***

Where was your child born?_____ Delivery type:☐Vaginal or ☐C-section

Any complications at birth?_____

Birthweight_____lb _____oz Planning to: ☐Breastfeed ☐Formula feed ☐Combination

Do you plan to vaccinate your child? ☐Yes ☐No ☐Partially ☐Undecided

***For school-age children:***

Child's school name_____ Current grade level_____

Do you vaccinate? ☐Yes ☐No ☐Partially

**Medical History**

| *Has your child ever been diagnosed with:* | | Comment/Detail |
|---|---|---|
| Asthma or airway disease | ☐ | _____ |
| Wheezing or bronchiolitis | ☐ | _____ |
| Seasonal allergies or eczema | ☐ | _____ |
| Food allergies | ☐ | _____ |
| Recurrent ear infections | ☐ | _____ |
| Jaundice | ☐ | _____ |
| Pneumonia | ☐ | _____ |
| Urinary tract infections | ☐ | _____ |
| Genetic syndrome | ☐ | _____ |
| Seizures | ☐ | _____ |
| Anemia | ☐ | _____ |
| Broken bones | ☐ | _____ |
| Cancer | ☐ | _____ |
| Learning disability | ☐ | _____ |
| Depression/anxiety | ☐ | _____ |
| Other | ☐ | _____ |

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**Medications** (name and dosage please)

_____

_____

_____

_____

**Allergies**

_____

_____

_____

**Hospitalization and/or Surgical History** **Date**

_____ _____

_____ _____

_____ _____

Is there anything else we should know about your child's medical or family history? Please list it below:

_____

_____

_____

_____

_____

_____

_____

_____

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Dear Patient,

It is our policy to keep all matters regarding our patients 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 in for information regarding your appointments, results, or any other medical information

**Persons I authorize to obtain information for/about me:**

NAME_____ RELATION_____

NAME_____ RELATION_____

NAME_____ RELATION_____

NAME_____ RELATION_____

NAME_____ RELATION_____

☐ Please check this box if you do not authorize anyone to obtain your information at this time

Patient or Guardian Signature_____ Date_____

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## 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 Privacy Practices.

Patient Name_____

Relationship to Patient (if not Self)_____

Signature_____Date_____

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*OFFICE USE ONLY*

I attempted to obtain the patient's signature in acknowledgment on this notice of Privacy Practice Acknowledgement but was unable to do so as documented below:

REASONS:

Date: Staff Initials:

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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 8:30am-5:00pm**

If you have an emergency after hours that cannot wait until normal business hours, please call our office and an operator will page the provider on call. Otherwise, please hold non-emergent matters until regular office hours.

***Please initial after reading each policy-regardless of applicability, unless otherwise noted***

## Clinic Policies

_____Refill Requests-please give at least 24-hour's notice on all refills. Contact your pharmacy first, and they will contact us with your needs. Refills will be authorized 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 of a medication before calling for a refill.

_____We require 24 hours' notice if you are unable to make your scheduled appointment with your provider. We understand that circumstances arise when you are unable to do so, but we ask that you do your best to provide adequate notice. Our office No Show fee is $26 for missed appointments or cancellations with less than 24 hours notice

_____Service/Emotional Support Animals are welcome in the office with certified documentation provided by a clinician. Animals must be leashed AT ALL TIMES and kept by your side

_____Parental consent is required for ALL medical services provided to patients under the age of 18, in accordance with Idaho Senate Bill No. 1329, effective July 1, 2024. Therefore, a parent or guardian must accompany minors for all appointments, or sign a consent form ahead of time that patient must present at check-in

_____If you are not seen by a provider at our office for more than 3 years, you will be classified as a New Patient when rescheduling and subject to appointment availability and charges as such.

_____If you are needing our office to complete FMLA/Short Term Disability paperwork on your behalf, please bring in ALL required forms for your employer/insurance at the same time. Multiple sets of paperwork brought in after the initial set may result in a $25 processing fee to be paid before completion of the forms

## Financial Policies

_____As a courtesy, we 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 with any questions. If payment is not received by insurance, the balance will become your responsibility

_____We require 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 we participate with them and if they will cover the services being provided to you. If your insurance requires a referral, it is your responsibility to ensure this is in place at the time of service. Failure to do so will lead to rescheduling your appointment.

_____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

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_____Some insurance companies bill labs through our clinic, and some do not. If your insurance does not bill through us, you will receive a charge from and pay directly to the lab company. Please ask our staff for list of insurances that bill directly to patients if you are interested

_____All Self Pay Patients (no insurance) will be required to pay in full at the time of service, unless a payment plan has been arranged with our billing manager. We offer a 20% discount on most services for uninsured patients. For your convenience, our staff can give an estimate of charges for your appointment, but these quotes are not exact

## Surgery Policies

_____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 required down payment by the above deadlines, your surgery may be postponed until payment is made

## Medicaid/Medicare Financial Policies ☐**Please check here if not applicable**

_____Medicaid patients on the Healthy Connections Program are be responsible for arranging referrals *ahead* of the appointment time. If referral from your listed Primary Care Physician is not received by our office at least 24 hours before your scheduled appointment time, your appointment will be rescheduled.

_____Your Medicaid ID number and/or card must be provided at time of service. Any charges that are accrued *before* Medicaid is active are the responsibility of the patient

_____Medicare only pays for routine physicals every two years. Please be aware that you may be billed for your exam or any other charges accrued from an annual physical visit if coverage is denied by Medicare

**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_____

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# 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 will 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 $26.00.** Insurance will not be billed or cover changes 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 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 I have scheduled. 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 $26 for a No Show or Late Cancellation

_____ _____ _____

Patient Name Date of Birth Today's Date

_____ _____

Patient Signature or Parent/Guardian signature if patient is a minor Relationship to Patient