TRIPP FAMILY MEDICINE

Today's Date: ____________________

NEW PATIENT DEMOGRAPHIC INFORMATION

Last Name__________________________ **First Name:** ______________________ **MI:** ____________

Preferred Name: _____________________ **SS#**______-______-_______ **DOB:**_____/_____/______

Sex: Male Female Race *(circle one)*: Caucasian Hispanic Other _____________________

Mailing Address: ______________________________________ **City/State:** _______________________

Preferred Phone: ( ) ______________________ **Texting? Yes No Zip Code:** ___________

Secondary Phone: ( ) _____________________ **Work Phone: ( )** _______________________

Email: ____ **OK to email? Yes No**

Employer & Address: ____

Parent/Spouse/Guardian Name: ____________________ **Marital Status:** **Married Single Divorced Widowed**

Other family members that have been seen in our office:

____

EMERGENCY CONTACT INFORMATION

Contact: ____ **Relation:** ___________________________

Phone (1): ___________________ **Phone (2):** _________________ **Email:** __________________________

Pharmacy you use: ___________________________ **City:** ______________________________

I came here because of a: (circle one) Doctor Family Friend Community Event Internet Banner Radio Billboard Mailer Phone Book TV Newspaper Other **Name:** _______________________________

Primary Insurance Policy Holder Information / Guarantor

Policy Holder name: _______________________ **Phone:** __________________ **SSN:**____-____-______

Address: ____________________________ **DOB:** ____/____/______ **Relation to Patient:** _________

Employer & Address: ____ **Phone:**__________________

Is this person the **GUARANTOR** on the account? ___ Yes ___No

Secondary Insurance

Policy Holder name: _______________________ **Phone:**________________ **SSN:**____-____-_______

Address:____________________________ **DOB:** ____/____/______ **Relation to Patient:**_________

Employer & Address: ____ **Phone:**__________________

 Today's Date: ____________________

PATIENT MEDICAL HISTORY

All Previous Providers: ____

CURRENT MEDICATIONS & DOSAGE (Please list type & dosage)

1. Medication ______________________________ **Dosage/how often** ______________________________

2. Medication ______________________________ **Dosage/how often** ______________________________

3. Medication ______________________________ **Dosage/how often** ______________________________

4. Medication ______________________________ **Dosage/how often** ______________________________

ALLERGIES WITH REACTIONS

1. Allergy _______________ **Reaction** ________________________**Severity** _________________________

2. Allergy _______________ **Reaction** ________________________**Severity** _________________________

3. Allergy _______________ **Reaction** ________________________**Severity** _________________________

PROCEDURES? *Please list the date of your most recent:*

1. PAP: date ________________ **2. Mammogram : date** ________________

3. Colonoscopy : date ________________

4. Hospitalization : date ________________ **reason** ____

SURGERIES?

1. year __________ **type** ____

2. year __________ **type** ____

3. year __________ **type** ____

Former smoker? ___ Yes ___ No How long? ____

Do you use chewing tobacco or snuff? ___ Yes ___ No How much per day?________________________

Do you smoke cigars or cigarettes? ___ Yes ___ No How many per day?_____________________________

Do you drink (circle) beer/wine/liquor? How many per day/week/month? ______________________ ___ No

Have you used any illegal or addictive drugs? ____Yes ___ No Type:________________________________

WOMEN ONLY – PREGNANCY HISTORY

Indicate quantity in the box:

Total pregnancies	☐	Full Term	☐	Premature	☐	Induced abortion	☐
Spontaneous abortion	☐	Ectopic	☐	Multiple Birth	☐	Living	☐

Date of last menstrual period _____________

TRIPP FAMILY MEDICINE

Today's Date: ____________________

*********CIRCLE SELF OR FAMILY MEMBER AND LIST SPECIFIC DISEASE**

DISEASE	FAMILY MEMBER		SPECIFY DISEASE
Acne	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Alzheimer's/Dementia	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Anemia/Bleeding Problems/Blood Disorder	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Arthritis (Osteo / Rheumatoid)	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Asthma/Bronchitis/COPD/ Emphysema	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Cancer (Skin, Colon, Lung, Breast, Ovarian, Other)	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Depression/Anxiety/ Other Mental Illness	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Diabetes	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Drug or Alcohol Dependency	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Heart Attack/Angina/Stroke	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Heart Burn/GERD	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Kidney/Hepatitis/Liver Disease	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
High Blood Pressure	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
High Cholesterol	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Intestinal/Stomach/Ulcers	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Urinary Disorders	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Osteoporosis	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Seizure Disorder	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Skin Disorder	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Thyroid Disease	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Tuberculosis	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	
Other (please describe)	**SELF** Mom Dad Brother Sister	**Paternal** Gma or Gpa **Maternal** Gma or Gpa	

I certify that the above medical history information is accurate and correct:

Patient Signature: ____Date: ____________

TRIPP FAMILY MEDICINE Today's Date: ____________________

1411 Fillmore St., Suite #600, Twin Falls, ID 83301
Phone 208-933-4400 Fax 208-933-4401

12/2015

1. **AUTHORIZATION OF TREATMENT:**
   I authorize **Tripp Family Medicine** to provide medical services to myself or my legal dependent, ______________________________. I understand I have the right to refuse medical services at any time. I further understand no guarantees have been made by any representative of Tripp Family Medicine as to the outcome of medical services provided.

Initials: ________

2. **BENEFITS RELEASE INFORMATION:**
   I authorize **Tripp Family Medicine** to release information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorized the payment of medical benefits for these services to be paid directly to Tripp Family Medicine. If any payment is made directly to me by my insurance company, I will remit that payment to Tripp Family Medicine immediately.

Initials: ________

3. **FINANCIAL RESPONSIBILITY:**
   I am or ___________________________ (the guarantor) is the person financially responsible for any debt in relation to service provided. I understand and agree to pay all insurance co-pays and amounts due for services not covered by insurance in advance at time of service, (these services may include after hour visits, urgent office visits, extended office visits, procedures and injections). I understand and agree that, except as otherwise provided by law, I am obligated to pay charges that are not paid by my insurance company. I am responsible for all costs of collecting monies owed, including court costs, collection agency fees, phone fees, and attorney fees. Any balances not paid within 90 days, will be subject to 15% interest (APR). A payment resulting in a credit less than $40 and not applied to a service is refundable upon my written request. Credits less than $40 will be held for 24 months then forfeited, if not requested in writing.

Initials: ________

4. **CONTACT POLICY:**
   I agree, in order to service my account(s), including all past, current and/or dependent accounts, or to collect any amounts I may owe for any past or current account(s), **Tripp Family Medicine** or their representative may contact me by telephone at any telephone number, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or e-mails to any of my phone numbers or e-mail accounts. Methods of contact may include using pre-recorded/artificial voice messages and/or use or an automatic dialing device, as applicable.

Initials: ________

 Today's Date: ___________________

5. **ACCESS TO PROTECTED HEALTH INFORMATION (PHI)**
   - ☐ No one, other than myself, my insurance and authorized medical staff can discuss my PHI.
   - ☐ Yes, I grant permission to Tripp Family Medicine and the person(s) listed on the Consent to Release Form access to my PHI. (see attached)

Initials: ________

6. **CANCELLATION AND NO-SHOWS:**
   We require 24 hours' notice of a cancellation. Not showing up, or showing up late, for my appointment can greatly affect the success of my treatment and not allow other patients the opportunity to be seen in a timely manner. I am aware there is a $25 charge for a cancellation or no show without proper notice, which is not covered by insurance and will be paid by me.

Initials: ________

7. **HIPAA CONSENT OMNIBUS** (Consent for use and Disclosure of Health Information):
   I have had full opportunity to read and consider the contents of the Notice of Privacy Policies and Practices for Tripp Family Medicine. I understand that, by signing this consent form, I am giving my consent to your (TFM) use and disclosures of my protected health information to carry out treatment, payment activities and healthcare operations.
   RIGHT TO REVOKE
   Written notice of revocation is required, and please note that as a result of revocation is required, and please note that as a result of revocation, Tripp Family Medicine may decline to treat me or continue my treatment.

Initials: ________

I, (print name)_____________________________________, have read, understand,

and agree to all 7 of the above statements, either for myself

or ______________________, (dependent) and will adhere to the above policies.

Signature: __________________________________ Date of Birth: ________________

(If the consent is signed by a personal representative on behalf of the patient, complete the following:)

Personal Representative's Name: ____

Relationship to the Patient: ____

For Tripp Family Medicine Use Only

Witness ____ Date ____/____/_____

TRIPP FAMILY MEDICINE Today's Date: ____________________

CONSENT FOR RELEASE OF PROTECTED PERSONAL HEALTH INFORMATION (PHI)

This form is used to authorize consent for Tripp Family Medicine
to communicate protected health information.

Patient whose information will be released:

Name: ____ Date of birth: ________ / _____/________

Address: ____

Information to be released:

Protected health information Tripp Family Medicine and its affiliates maintain, including mental health, HIV, health status or substance abuse records related to area/illness we treat. This also includes sharing information on mail-order pharmacy, appointments, finances, wellness products, and health programs with authorized person.

This information may be disclosed to, and used by, the following person or organization (such as nursing home or care provider) to assist me with the Tripp Family Medicine products or services. I understand that this authorization will allow Tripp Family Medicine and its affiliates to use or disclose the protected health information described above.

Person information will be released to:

Relationship: ☐Spouse ☐Sibling ☐Parent ☐Child ☐Agent/Broker ☐Friend ☐Organization

Name: ____ Date of Birth: ________ / _____/_________

Address: ____Phone: _____________________________

I understand: My consent will expire in 24 months unless I cancel it before that time. I can cancel my consent through my Tripp Family Medicine account or by submitting a written notice to Tripp Family Medicine. If I cancel consent, it will not apply to any information previously released with this authorization. Once information is shared, Tripp Family Medicine cannot prevent the person or organization who has access to it from sharing that information with others, and this information may not be protected by federal privacy regulations. I am not required to sign this consent and Tripp Family Medicine cannot base decisions regarding treatment or payment on whether I sign it.

Signature ____Date: ____ / ____ / _____

☐**Patient**
☐**Written**
☐**Verbal**

☐ **Legal Representative.** Please note: Legal representatives must attach copies of authorization as required by law. Examples include healthcare power of attorney, healthcare surrogate, and living will or guardianship papers.

For Tripp Family Medicine Use Only

Witness ____ Date ____/____/_____

Notice of Privacy Policies and Procedures

Dear Patient,

This notice describes how information about you may be used and disclosed and how you can get access to this information. This is in compliance with HIPPA laws. PLEASE REVIEW IT CAREFULLY.

Introduction

At Tripp Family Medicine, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice applies to all protected health information as defined by federal regulations.

Understanding Your Medical Record/Health Information

Each time you visit **Tripp Family Medicine** a record of you visit is made. Typically, this record contains information about your visit including your examination, diagnosis, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing that care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to asses and/or improve state as well as national healthcare standards
- A source of data for panning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

Your Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Our Responsibilities

Tripp Family Medicine is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice
- Notify your if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according procedures included in the authorization.

How We May Use and/or Disclose of Your Health Information

- **We will use your health information for treatment.** Your health information may be issued by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
- **We will use your health information for payment.** Your health plan may request information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.
- **We will use your information for regular health operations.** Your health information may be used as necessary to support the day-to-day activities and management of **Tripp Family Medicine.** For example: information on the services you received may be issued to support budgeting and financial reporting, and activities to evaluate and promote quality.
- **Business Associates.** In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in or to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be billing service, collection agency, answering services and computer software/hardware provider.
- **Communication with family.** Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you **DO NOT** wish a family member or other individual to have authorization to receive your information.
- **Research/Training/Teaching.** We may use your information for the purpose of research, teaching and training.
- **Healthcare Oversight.** Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/states appointee if there are circumstances that require us to do so.
- **Public Health Reporting.** Your health information may be disclosed to public health agencies as required by law.
- **Law Enforcement.** Your Health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.
- **Appointment reminders.** The practice may use your information to remind you about up-coming appointments. Typically, appointment reminders are sent by mail in a closed envelope, or, a brief, non-specific message may be left on you answering machine. If you don't approve of these methods, or, if you prefer alternative methods (i.e. e-mail) please inform the practice.
- **Other uses and disclosure.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision.

For More Information to Report a Problem
If you have any complaints, questions or would like additional information regarding this notice or the privacy practices of **Tripp Family Medicine, Please call 208-933-4400**

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201