Post Falls Family Medicine, PA
NOTICE OF PRIVACY PRACTICES
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEIDCAL INFORMAION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

About Us
In this notice, we use terms like "we", "us" or "our" to refer to Post Falls Family Medicine, PA and it's physicians. We are a family practice specializing in keeping you and your family in good health.
This notice applies to Post Falls Family Medicine and its physicians.

What is "Protected Health Information" or "PHI"?
"Protected health information", or "PHI" for short, is information that identifies who you are and relates to, your past, present and future physical or mental health or condition, the provision of health care to you, or past, present or future payment for the provision of health care to you. PHI does not include information about you that is publicly available or that is in a summary form that does not identify who you are. If you are an employee of our participating physician's office, PHI does not include your health information in your personal life.

Purpose of this notice
In the course of doing business, we gather and maintain PFI about our patients. We respect the privacy of your PHI and understand the importance of keeping this information confidential and secure. This notice describes our privacy practices and how we protect the confidentiality of our PHI. We are obligated to maintain the privacy of your PHI implementing reasonable and appropriate safeguards. We are also obligated to explain to you by this notice about our legal obligations to maintain the privacy of your PHI. We must follow our notice that is currently in effect.

How we protect your PHI
We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical, electronic, and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a privacy officer, which has overall responsibility for developing, training, and overseeing the implementation and enforcement of polices and procedures to safeguard your PHI against inappropriate access, use, and disclosure.

Types of use and disclosure of PHI we may make without your authorization
Treatment; Payment; Health Care Operations
Federal and state law allows us to use and disclose our PHI in order to provide health care services to you, as well as to bill and collect payments for the health care services provided to you by our physicians. For example, we may use your PHI to authorize referrals to specialists and to review the quality of care provided by your participating physician. We may disclose your PHI to health plans or other responsible parties to receive payment for the services provided to you by our physicians.

We may also use or disclose your PHI, for example, to recommend to you treatment alternatives, to inform you about health-related benefits and services that we offer or to contact you to remind you of our appointments. We conduct these activities to provide health care to you and not as marketing.

Federal and state law also allows us to use and disclose your PHI as necessary in connection with our health care operations. For example, we may use your PHI for resolution of any grievance or appeal that you file if you are unhappy with the care you have received. We may also use our PHI in connection with population-based disease management programs. We may use or disclose your PHI to perform certain business functions to our business associates, who must also agree to safeguard your PHI as required by law.
We are also allowed by law to use and disclose your PHI without your authorization for the following purposes:

1. When required by law- In some circumstances, we are required by federal or state laws to disclose certain PHI to others, such as public agencies for various reasons.
2. For public health activities- Such as report about communicable diseases, defective medical devices to the FDA or work-related issues.
3. Reports about child and other types of abuse, neglect, or domestic violence.
4. For health oversight activities- Such as reports to governmental agencies that are responsible for licensing physicians or other health care providers.
5. For lawsuits and other legal disputes- In connection with court proceedings or proceedings before administrative agencies or to defend us or our participating physicians in a legal dispute.
6. For law enforcement purposed- Such as responding to a warrant or reporting a crime.
7. Reports to coroners, medical examiners, or funeral directors- To assist them in performance of their legal duties.
8. For tissue or organ donations- To organ procurement or transplant organizations to assist them.
9. For research- To medical researchers with an approval of an institution review board (IRB) or privacy board that oversees studies on human subjects. Researchers are also required to safeguard our PHI.
10. To avert a serious threat to the health or safety of you or other members of the public.
11. For national security and intelligence/military activities- Such as protection of the President or foreign dignitaries
12. In connection with services provided under workers' compensation law.

We may disclose your PHI, without your written authorization, to your family members or other persons if they are involved in your care or payment for that care. We may also notify disaster relief organizations to assist them with their relief efforts. When you are a patient at a hospital or medical facility with which we are affiliated, we may create a directory that includes your name, your location at the facility, your general condition and your religious affiliation. Information in this director may be disclosed to visitors and clergy. However, we must first provide you with an opportunity to agree to such disclosure. If you cannot agree or object because you are incapacitated or otherwise unavailable, we will use our professional judgment.

You, as a parent, can generally control your minor child's PHI. In some cases, however, we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission.

There are some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. However, even such PHI may be used or disclosed without your written authorization if required or permitted by law.

Authorization
All other uses and disclosures of your PHI must be made with your written authorization.

If you need an authorization form, we will send you one for you or your personal representative to complete. When you receive the form, please fill it out and send it to the following address:

Post Falls Family Medicine, PA
1220 E. Polston Ave.
Post Falls, ID 83854

You may revoke or modify your authorization at any time by writing to us at the same address. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

Your rights regarding your PHI
Access to your PHI
You have the right to review and copy your PHI we maintain. If you wish to access your PHI, please write to us. We will respond to your request and tell you when and where you can review your PHI in our possession within our normal business hours. If you would like a copy of the information we have, please write to us at the same address. If we provide you with a copy, we may charge a reasonable administrative fee for copying your PHI to the extent permitted by applicable law. If we deny your request for review or copy of your PHI, we will explain the reason in writing. If we do not have your PHI, but know who does, we will tell you whom to contact.

Right to Amend your PHI
You have the right to request amendments to your PHI. If you wish to have your PHI corrected or updated, please write to us and tell us what you want changed and why. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why. You may also send us an addendum that is no longer than 250 words in length for each item you believe is incorrect. Please clearly indicate that you want the addendum to be included in your PHI. We will attach your addendum to the record(s) of your PHI. Your amended PHI will be available for your review upon request.

Right to Receive an accounting of disclosure of your PHI
You have the right to request an accounting of certain disclosures that we make of your PHI. You can request an accounting by writing to us. Please note that certain disclosures, such as those made for treatment, payment or health care operations, need not be included in the accounting we provider to you. We will respond to your request within a reasonable period of time but no later than 60 days after we receive your written request.

Right to receive a copy of this notice
You have the right to request and receive a paper copy of notice.

Right to request restrictions
You have the right to request restrictions on how we used and disclosed your PHI for our treatment, payment, and health care operations. All requests must be made in writing. Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Please note that we are not required to accept your request for restrictions. Your PHI is critical for providing you with quality health care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI and that additional restrictions may be harmful to your care.

Right to confidential communications
You have the right to request that we prove our PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternative means (e.g. sending by a sealed envelope, rather than a post card) or to an alternate address (e.g. calling you at a different telephone number or sending a letter to you at your office address rather than your home address). We will accommodate any reasonable request, unless they are administratively too burdensome or prohibited by law.

Right to complain
We must follow the privacy practices set forth in this notice while in affect. If you have any questions about this notice, wish to exercise your rights, or file a complaint; please direct your inquiries to:

Post Falls Family Medicine, PA
1220 E. Polston Ave.
Post Falls, ID 83854

You may contact your health plan or the Idaho Medical Association with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint against us.
Rights reserved
We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in this notice. We reserve the right to revise our privacy practices consistent with law and make them applicable to your entire PHI we maintain, regardless of when it was received or created. If we make material or important changes to our privacy practices, we will promptly revise our notice. Unless, law requires the changes, we will not implement material changes to our privacy practices before we revise our notice. You may request updates to this notice at any time.
Effective date of notice is 02/01/2003

I, the undersigned patient, and/or responsible party have read and received a copy of Post Falls Family Medicine, PA's Privacy Statement.

PRINT NAME: _____ **DATE OF BIRTH**: _____

SIGNATURE: _____ **DATE**:_____

Post Falls Family Medicine, P.A.

Office Policies

Release of Information

I (we) the undersigned patient and/or responsible party hereby authorize this office, its agents/employees to release and disclose all or part of the patients' medical records to any entity, which is, or may be liable for all or part of the provider charges.

I (we) authorize the release and disclosure or any and all medical records to any other entity including by not limited to referring physicians, hospitals or other health care providers which may be of assistance in the opinion of this office, in providing for the treatment of patient.

I (we) authorize the release of records necessary as assist in reimbursement of benefits to which I (we) may be entitled. I (we) authorized this office and/or its employees to release via fax machine medical records which are needed in order to provide patient with the most appropriate medical care.

I (we) authorize the release of my x-rays, labs and medical results to be left on my answering machine if I am unavailable. **Yes____ No_____**

I (we) the undersigned patient and/or responsible party hereby authorize this office to release medical, billing and appointment information to the following family members in lieu of myself:

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

Financial

Post Falls Family Medicine, PA is happy to bill our patients insurance carriers as a courtesy when they present with a current insurance card, however, we are not contracted with all insurances nor do we know your individual policy, so please contact your carrier before you are seen to verify your benefits for services you may receive. It is ALWAYS the patient's responsibly to know their insurance carriers benefits and polices.

Lab

Post Falls Family Medicine offers on site lab services for the convenience of our patients. Post Falls Family Medicine bills for insurance types: Asuris, Blue Cross, First Choice, Group Health, Premera and Regence. LabCorp bills all other insurances. If you have any questions about your lab services that LabCorp has billed please feel free to contact their billing department.

Agreement to Pay for Treatment

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with which this office has a contractual agreement, the patients and/or responsible party also agree to pay for treatment rendered to patient. In the case of non-payment by contracted carrier, patient is ultimately responsible for payment and follows up with carrier for series rendered.

I realize that failure to keep this account current may result in my being unable to receive additional services except for emergencies. In the case of default on payment, I understand that my account may be turned to a collection agency along with possible termination of care with this clinic.

No Show/Missed Appointment Policy

A minimum of **24 hours cancellation** notice is required for appointments; enabling us adequate time to offer the cancellation slot to another patient. If less than 2-hour cancellation is given, the appointment becomes a "missed" appointment. If you fail to show up at all for your appointment, it will be considered a "no show" appointment.

After the first "no show/missed" appointment, you will receive a letter from our office notifying you that the missed appointment will be recorded as such in your chart.

If you incur a 2nd "no show/missed" appointment, with in a one year time period, you will receive a letter from our office notifying you that you have been charged a $35 missed appointment fee. **These fees must be paid prior to being seen at your next visit. You are responsible for any no-show fees you are charged; your insurance company will not be billed.**

If you incur a 3rd "no show/missed" appointment within a one year time period, you will received another letter from our office and may face dismissal from the practice at the discretion of the doctor.

I, the undersigned patient, and/or responsible party have read and received a copy of Post Falls Family Medicine's policies.

Signature: _____ Date: _____

Post Falls Family Medicine, P.A.

Patient Demographic Information

Today's Date: _____ How did you hear about us? _____

PATIENT INFORMATION

Name: _____ Nickname: _____ Previous/Maiden Name: _____
Male: __Female: __ **Date of Birth**: _____Age: _____Social Security #: _____ Email: _____
Single: _____ Married: _____ Divorced: _____ Widowed: _____

Physical Address: _____City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Cell/Alternative: _____ Work Phone: _____
Which phone number is preferred? Home _____ Cell _____ Work _____ Language Preference: _____

Race (government census):
White_____ American Indian or Alaskan Native _____ Asian _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _____Decline to Specify_____
Ethnicity:
Hispanic or Latino _____ Not Hispanic or Latino _____ Declined to specify_____

Employer: _____ **Phone**: _____
Employer Address: _____ City: _____ State: ____ Zip: _____

FRIEND OR RELATIVE **NOT** LIVING WITH YOU THAT WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU:

Name: _____ Relationship: _____ Phone: _____
Address: _____City: _____ State: _____ Zip: _____

PERSON RESPONSIBLE FOR ACCOUNT

Please note, just because a spouse/parent carries the insurance plan, does not mean they are responsible for the balance due after insurance has processed.

☐ Self

Name: _____ Phone/Cell: _____
Relationship: _____ Social Security #: _____ Date of Birth: _____
Employer: _____ Employer Phone: _____
Address: _____ City: _____ State: _____Zip: _____

PATIENT'S SPOUSE INFORMATION

☐ N/A

Name: _____Date of Birth: _____ Social Security #: _____
Employer: _____ Work Phone: _____ Cell/Alt: _____

Please list all other family members that are seen here: (i.e. mom, dad, siblings)

_____

_____

Who referred you? _____

Post Falls Family Medicine, P.A.

Family Practice & Pediatrics
Moms, Dads, Kids & Babies

Child(ren) Demographic Information

Today's Date: _______________ How did you hear about us? ___________________________

Child's full Name: ____ **Date of Birth**: _____________ SS#: _______________ M or F
Race (government census):
American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______
Declined to Specify ______
Ethnicity:
Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______
Language Preference: ______________

Additional children: (if any)
Child's full Name: ____ **Date of Birth**: _____________ SS#: _______________ M or F
Race (government census):
American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______
Declined to Specify ______
Ethnicity:
Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______
Language Preference: ______________

Child's full Name: ____ **Date of Birth**: _____________ SS#: _______________ M or F
Race (government census):
American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______
Declined to Specify ______
Ethnicity:
Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______
Language Preference: ______________

Child's full Name: ____ **Date of Birth**: _____________ SS#: _______________ M or F
Race (government census):
American Indian or Alaskan Native______ Asian______ Black or African American______ White______ Native Hawaiian or Other Pacific Islander______
Declined to Specify ______
Ethnicity:
Hispanic or Latino _______ Not Hispanic or Latino _______ Declined to specify______
Language Preference: ______________

Do the child/children live with both parents? **Y/N** If not, who is the legal guardian? ________________________________
Child's Physical Address: ________________________________City: _________________ State: _____ Zip: ___________
Child's Mailing Address: __________________________________ City: __________________ State: _____ Zip: _________
Best contact phone #: _____________________ whose phone is this ________________ Alt. phone: _________________

Mother's Information

Mother's full name: ____________________________ Phone/Cell: _________________________ SS#: ______________
Address: _______________________________________ City: _______________________ State: _____ Zip: _________

Father's Information

Father's full name: ____________________________ Phone/Cell: _________________________ SS#: ______________
Address (if different from Mother's): ________________________________ City: _______________ State: _____ Zip: _________

Person Responsible for the account

(No absent parent billing)

Please note, just because a parent carries the child under their insurance plan, does not mean they are responsible for the balance due after insurance has processed. Please indicate who will be responsible for the account.

☐ Mother ☐ Father ☐ Other: ____________________________

PRE-HISTORY INFORMATION

Name: _____ **Date**: _____
Date of Birth: _____ **Age**: _____ **Referred By**: _____

1. **State in your own words the major medical reason(s) for coming in today:**

   _____
   _____
   _____.

2. **Please list all medications that you use. Please bring these with you:**

   _____
   _____.

3. **Drug Allergies? None: _____ If yes, please list: _____.**

4. **Family History: please indicate the health or cause of death of members of your family as best as you can:**

	Age if Living	Age at Death	Indicate any serious diseases	Cause of death
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				
Other				

Please indicate which of your relatives has any of the following diseases:
Cancer: _____ Diabetes: _____
Heart Problems: _____ High Blood Pressure:_____
Kidney Disease: _____ Mental/Emotional Problems: _____
Stroke: _____ Tuberculosis: _____
Arthritis: _____ Other: _____

5. **Menstrual History**

Number of pregnancies	
Number of live births	
Last menstrual period	
Age at menopause	

6. **Please indicate by checking yes or no if you have had significant problems in the below areas. Please comment on special problems and indicate approximate dates:**

Yes	No	Nature of Problem	Comment/Approximate Dates
		Recent weight loss	
		Headaches	
		Trouble with vision	
		Trouble with hearing	

Yes	No	Nature of problem	Comment/Approximate Dates
		Allergic Reaction to medications? Name:	
		Allergies: Hay Fever? Asthma?	

		Thyroid (Goiter)	
		Diabetes	
		Skin Problems	
		Anemia or Abnormal Bleeding	
		Heart Problems	
		Circulation Problems	
		High Blood Pressure	
		Chest Pain	
		Lung Problems (Pneumonia, TB, etc.…)	
		Shortness of breath, coughing, pleurisy, wheezing	
		Liver Disease, Gallbladder disease, Jaundice	
		Stomach problems: Ulcers, indigestion, change in bowels, constipation, diarrhea	
		Abdominal Pain	
		Kidney disease or stones	
		Urination Problems	
		Female organs	
		Joint Pain or Stiffness	
		Phlebitis	
		Do you smoke? How much?	
		Do you drink alcoholic beverages? How much?	
		Coffee? How much?	
		Depression	
		Nerves, difficulty sleeping	
		Psychiatric	
		Fainting or convulsion	
		Stroke	
		Pain in other areas	
		Other Illness or problems	

7. Please give details of any of the following:

	Approximate Dates	**Surgeon**	**Hospital**
Operations:			
Serious Injuries:			

PLEASE BE SURE THAT YOU HAVE FILLED OUT BOTH PAGES OF THIS FORM!

Please feel free to attach any other recorded information, which you feel, will be of importance to the doctor in evaluating your health problems.