Idaho Falls Pediatrics
2375 Coronado, Idaho Falls, ID 83404
Ron Porter M.D. • Scott Smith D.O. • Joseph Moore M.D.
Stephanie Newberry PAC • Darin Leslie PAC
(208)522-4600 • Fax (208) 552-7521

INFORMATION SHEET

Referred by: ___________________________________

Father or Guardian_________________________ Mother or Guardian_______________________

Father's DOB_____________________________ Mother's DOB___________________________

Father's SSN#_____________________________Mother's SNN#___________________________

Home Phone _____________________________ Cell Phone ______________________________

Mailing Address ____
STREET CITY STATE ZIP

Mailing Address ____
STREET CITY STATE ZIP

Marital Status MARRIED SINGLE DIVORCED

Father's Employer ____
NAME ADDRESS PHONE

Mother's Employer ____
NAME ADDRESS PHONE

PLEASE LIST THREE PEOPLE WHO DO NOT LIVE WITH YOU THAT WE CAN CONTACT IN CASE OF EMERGENCY. PLEASE LIST COMPLETE ADDRESS AND PHONE NUMBER INCLUDING AREA CODE

Name _____________________ Address___________________________Phone _______________

Name _____________________ Address___________________________Phone _______________

Name _____________________ Address___________________________Phone _______________

PLEASE LIST CHILDREN (BIRTH TO 19 YRS)

FIRST NAME	MIDDLE	LAST NAME	SEX	DATE OF BIRTH	CURRENT PT Y/N

PLEASE COMPLETE INSURANCE INFORMATION

Primary Insurance Company ____

Complete Address ____

Phone Number ________________________________

Subscriber Name _____________________________ **Date of Birth** _______________

SSN _________________________ **Address** _________________________________

Subscriber ID # ______________________________ **Group #** ___________________

Secondary Insurance Company ____

Complete Address ____

Phone Number ________________________________

Subscriber Name _____________________________ **Date of Birth** _______________

SSN _________________________ **Address** _________________________________

Subscriber ID # ______________________________ **Group #** ___________________

Third Insurance Company

Complete Address ____

Phone Number ________________________________

Subscriber Name _____________________________

Subscriber ID # ______________________________ **Group #** ___________________

PAYMENT IS DUE at the time of service. All Co-payments will be collected prior to visit. If for some reason a co pay is not left and a bill needs to be sent for the co pay, a $5.00 charge will be added to the bill. All extended credit must be approved through the office manger. Any balance over 60 days may receive a finance charge of 12% annum. I authorize assignment of benefits to Idaho Falls Pediatrics and authorize above named clinic to release any information requested to receive payment. If collection becomes necessary, the undersigned shall pay any expense incurred for collection procedures including court and attorney fees.

SIGNATURE (Parent or Legal Guardian) _______________________________________

DATE ______________________

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In consideration of professional services rendered, I agree to pay your customary charges for these services to Dr. Ron Porter, MD or Dr. Scott Smith, DO or Dr. Joseph Moore, MD, Stephanie Morgan, PA-C, or Darin Leslie, PA-C. As a benefit to our patients this office submits insurance claims directly to your insurance company. It is however, **ultimately your responsibility** to be sure that the claim is paid by the insurance company. I hereby authorize Dr. Ron Porter, Dr. Scott Smith, Dr. Joseph Moore, or Stephanie Morgan to receive assignment of insurance payments. If the customary charges are more than the benefits allow under the responsible party's insurance plan, and we are not participating providers with said plan, I agree to pay the difference. I understand that if it becomes necessary to turn this account to collections, collection fees and interest will be charged and I will be responsible for them.

NAME OF PARENT OR GUARDIAN

PRINT____

SIGNATURE____

DATE _________________________

I authorize Dr. Ron Porter, Dr. Scott Smith, Dr. Joseph Moore, MD, Stephanie Morgan, PA-C, or Darin Leslie, PA-C to release any medical or incidental information that may be necessary for either medical care or in processing applications for medical or financial benefit.

SIGNATURE OF PARENT OR GUARDIAN

PRINT____

SIGNATURE____

DATE ___________________________

OUR FINANCIAL POLICY

Thank you for choosing Idaho Falls Pediatrics as your healthcare provider. We are committed to your children's treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

All Patients must complete our information and Insurance form before seeing the doctor.

ALL CO-PAYS ARE DUE AT THE TIME OF SERVICE. PATIENTS WITH NO INSURANCE WILL BE OFFERED 15% OFF OF BILL IF IT IS PAID IN FULL AT THE TIME OF SERVICE.

WE ACCEPT CASH, VISA AND MASTERCARD AND DISCOVER. WE NO LONGER ACCEPT CHECKS..

Regarding Insurance

We will file your insurance as a courtesy to you and will do our very best to maximize your benefits. All co-pays and deductibles are to be paid at the time of service. If co-pay is not left, we reserve the right to assess a $5.00 charge in addition to the charges for that day. If there is a problem with a claim, you will need to contact your insurance company. After you contact the insurance company, if there is anything we need to do to assist you, please call and let us know. You are responsible for the amount your insurance company does not pay. We do contract with most insurance companies and will take their usual and customary allowances. If, however, you happen to have an insurance that we are not contracting with, you are responsible for the full remainder of the bill after insurance pays.

MEDICAID: If you have Medicaid and your Medicaid is ineligible the day of your visit, you will be required to pay in full at the time of service or reschedule until you can get your Medicaid fixed.

Minor Patients

An adult must accompany any child under 18 years of age. The adult or guardian accompanying the minor is responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied.

Missed Appointments

Appointments must be canceled at least 24 hours in advance. Our policy is to charge for missed appointments at a rate of $20.00. Please help us serve you better by keeping scheduled appointments.

Returned Checks

If your check is returned to us for NSF, a $20.00 charge will be applied to your account.

These financial options will meet the needs of most families in our practice. We want to be flexible in these changing times. We will do our very best to work out a financial solution to your particular situation. We are here to help you.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL STATEMENT.

Signature: DATE -____

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On occasion, you may wish to have your child/children brought to the Clinic by someone other than a parent. Please the list of those individuals (A grandparent or a daycare provider, for example) who have your permission to bring your child in for assessment and treatment.

My child ________________________________, may be brought in for assessment and treatment by the following individuals:

NAME	RELATIONSHIP TO CHILD
________________________________	______________________
________________________________	______________________
________________________________	______________________
________________________________	______________________

____
Custodial Parent or Legal Guardian

____
Witness

____
Date

HIPPA Notice of Privacy Practices

Idaho Falls Pediatrics

2375, Idaho Falls, ID 83404
Ron Porter, M.D., Scott Smith, D.O., Joseph Moore, M.D.
(208) 522-4600, Fax (208) 552-7521

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide , coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health oversight, Abuse or Neglect, Food and Drug Administration requirements: Legal Proceedings; Law Enforcement; Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes that it is in your best interest to permit use and disclosure of your protected health information, your protected health information will be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at a n alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will be retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practice with respect to protected health information. If you have objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: ____

Signature: ____

Date: ______________________