Patient Registration Form

Patient Information

Patient Name (Last): _____ (First): _____(MI)_____ Previous Name: _____
Social Security Number: _____-_____ -_____ Date of Birth: _____ Sex: ☐ Male ☐ Female
Street Address: _____ City, State, Zip: _____
Mailing Address: _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____Work Phone: _____
Preferred number at which to reach you: ☐ Home ☐ Cell ☐ Work Email Address:

_____
Preferred pharmacy: _____

Do you or your family member have any special communication needs? _____
Type of Interpreter Needed: None Deaf/Hard of Hearing Visually Impaired Foreign Language Interpreter Other: _____
In what language do you prefer to discuss your healthcare? _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Declined
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Primary Care Provider: _____ Referring Provider: _____

Emergency Contact:

(Last Name): _____ (First Name): _____
Phone Number: _____ Relationship to Patient: _____
Address:_____City, State, Zip: _____

Responsible Party Information

Relationship to Patient: _____ *Check if information is same as patient:* ☐
Responsible Party Name (Last): _____ (First)_____(MI) _____
Date of Birth: _____ Social Security Number: _____ -_____- _____Sex: ☐ Male ☐ Female
Address: _____ City, State, Zip: _____
Email Address: _____ Employer: _____
Employer Phone Number: _____

Primary Insurance Information ☐ As of this date, I have no insurance.

Insurance Company Name: _____ Insurance Company Phone Number: _____
Subscriber ID: _____ Group Number: _____ Copay Amount: _____
Effective Date: _____ Termination Date: _____
Insurance Subscriber same as responsible party? ☐ Yes ☐ No Relationship to Patient: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Social Security Number: _____- _____ - _____ Subscriber Phone Number: _____

Secondary Insurance Information ☐ As of this date, I have no secondary insurance.

Insurance Company Name: _____ Insurance Company Phone Number: _____
Subscriber ID: _____ Group Number: _____ Copay Amount: _____
Effective Date: _____ Termination Date: _____
Insurance Subscriber same as responsible party? ☐ Yes ☐ No Relationship to Patient: _____
Subscriber Name: _____ Subscriber Date of Birth: _____
Subscriber Social Security Number: _____- _____ - _____ Subscriber Phone Number: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge, and I further give my permission to the providers at Unified HealthCare of Idaho to treat me, and my medical condition(s).

Patient (or Responsible Party) Signature: _____ Date: _____

Pt. Name: _____

Patient HIPAA Acknowledgment and Consent Form

Your information. Your rights. Our responsibilities.

Patient Name: _____ Date of Birth: _____

Please initial the following:

_____**Notice of Privacy Practices.** I acknowledge that I have received the clinic's Notice of Privacy Practices, which describes the ways in which the practices may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the clinic's Notice of Privacy Practices.

_____**Release of Information.** I hereby permit the clinic and the medical providers or other health professionals involved in outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.
- This office has chosen to participate in the Idaho Health Data Exchange (IHDE). The IHDE is an organization of participating medical providers throughout the state of Idaho that enables the sharing of health information for the improvement of access, availability and coordination of healthcare. If you do not want to participate in the IHDE and you do not want to have your health care information shared with other medical providers involved in your care, you can opt out of the participation. To opt out of sharing your records through the IHDE, please fill out a "Request to Restrict Disclosure of Health Information" form available to you by the front office staff.

Release of Information:

I give permission to release my medical information to be disclosed for purposes of communicating results, findings and care decisions to the family members, friends, and other establishments listed below:

Name	Relationship	Phone Number
Tueller Counseling Services Inc.	Mental Health Services	208-524-7400

Patient may revoke or modify this specific authorization- the revocation or modification must be in writing.

Patient Signature: _____ Date: _____

TUELLER COUNSELING SERVICES
UNIFIED
HEALTHCARE OF IDAHO

Pt. Name: _____

Financial Policy Acknowledgement

Tueller Counseling Services, Inc. & Unified HealthCare of Idaho are dedicated to providing the best patient-centered care, ensuring our clients have improved access to care, and making sure that no client will be denied healthcare services (medical or behavioral health) due to an inability to pay. We provide discounted care to those who are underinsured or uninsured – ***Ask us about our Sliding Fee Discount Program***.

We participate in most major health plans. We have contracts with many insurance companies and government agencies including Medicare and Medicaid. Our office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. *It is the member's responsibility to provide all necessary information before leaving the office.*

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, check or the following credit cards: Visa, MasterCard, and Discover. If you do not have your co-payment, your appointment may be rescheduled. If it is necessary that you be seen, a $25 Copay Service Charge will be billed to your account. You may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting your insurance's responsibility, will be billed to you.

It is the policy of Tueller Counseling Services, Inc. & Unified HealthCare of Idaho to treat all patients in an equitable fashion related to account balances. We will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's **Sliding Fee Schedule Policy**.

Please note:

- Payment is due at the time of service.
- If you do not pay the full amount due at the time of service, your account will be billed.
- Payment plans are available upon request.
- Please bring your insurance card with you at the time of your appointment.
- If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit may be required until we can verify your coverage.
- A cancellation *fee will be charged, if:
  - You do not show for a scheduled appointment;
  - You do not contact the clinic within 24 hours (with a minimum of four hours) to cancel your appointment;
  - You are more than fifteen minutes late to your appointment;
  - The cancellation *fee is due before or on your next visit
- Balances that are more than 94 days overdue may be sent to a collection agency.

*Cancellation Fee amount will be determined on the service for which you had an appointment.

*If enrolled in the sliding fee scale program, the charge is based off 50% the original discounted price.

I, _____ (print name), have read Tueller Counseling Services, Inc. & Unified HealthCare of Idaho's Financial Policy.

Patient/Responsible Party Signature: _____ Date: _____

Pt. Name: _____

Adult Health History Form

The answers on this form will help your healthcare provider better understand your medical concerns and conditions. If you cannot remember specific details, please provide your best guess.

Patient Name: _____ Date of Birth: _____

How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Main reason for today's visit: _____

Other concerns: _____

Review of Symptoms: Please check any current symptoms you may have.

Constitutional
____Unexplained weight loss/gain
____Recent fevers/sweats
____Unexplained fatigue/ weakness
____Recent chills/cold sweats

Cardiology
____Chest pains/discomfort
____Palpitations
____Decreased exercise tolerance

Dermatology
____Rash
____New or change in mole

Endocrinology
____Cold/heat intolerance
____Increase thirst/appetite

Ear, Nose, and Throat
____Change in hearing
____Congestion
____Sinus pain
____Sore throat

Hematology/Lymph
____Unexplained lumps
____Easy bruising/bleeding

Genitourinary
____Painful/bloody urination
____Leaking urine
____Nighttime urination
____Frequent urination
____Discharge: penis or vagina
____Concern with sexual functions

Gastroenterology
____Heartburn/reflux
____Bloody stools
____Change in bowel movement
____Nausea/vomiting/diarrhea
____Pain in abdomen

Musculoskeletal
____Muscle/joint pain
____Recent back pain
____Weakness
____Swollen joints

Neurology
____Memory loss
____Headaches
____Fainting
____Numbness/tingling in hands/feet
____Loss of balance

Ophthalmology
____Change in vision
____Eye pain

Psychology
____Anxiety/stress
____Sleep problems
____Depression
____ADD/ADHD
____Medication Management

Respiratory
____Cough/wheeze
____Coughing blood
____Short of breath with exertion
____Pain with breathing

Women
____No periods
____Heavy periods
____Painful periods
____Irregular periods
____Unusual vaginal bleeding
____Breast lump
____Nipple Discharge
Menopause at age: _____

Over the past two weeks, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you're a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that others could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
If you checked off any problems how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

Pt. Name: _____

Medications: Prescription and non-prescription medicine, vitamins, home remedies, birth control, herbs, etc.

Medication/Vitamin/Supplement	Dose/Strength (mg/pill)	How many times per day

Allergies: Do you have any allergies or reactions to:

Medication	Reaction

Food	Reaction

Immunizations: Date of most recent record

____Hepatitis A ____Tetanus (Td) ____MMR
____Meningitis ____Influenza (flu shot) ____Pneumovax (pneumonia)
____Hepatitis B ____Varicella (chicken pox) or illness ____Tdap (tetanus and pertussis)

Health Maintenance: Date of most recent record.

Cholesterol_____ Abnormal? ☐ Yes ☐ No
Colonoscopy_____ Abnormal? ☐ Yes ☐ No
Bone Density Scan_____ Abnormal? ☐ Yes ☐ No
Women: Mammogram_____ Abnormal? ☐ Yes ☐ No
Men: PSA (prostate)_____ Abnormal? ☐ Yes ☐ No
Pap Smear_____ Abnormal? ☐ Yes ☐ No

Medical History:

Major Illnesses: (high blood pressure, high cholesterol, depression, diabetes, etc.)	Year of Diagnosis	Currently Treated?	Surgeries:	Year of Surgery	Reason for Surgery

Family History: Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions. Please also include if it is on your **paternal or maternal** side. (ex. Paternal Grandmother, Maternal Aunt, ext.)

Alcoholism _____
Cancer, specify type _____
Heart disease _____
Depression/suicide _____
Genetic disorders _____
Diabetes _____
Kidney Disease _____
High cholesterol _____
High blood pressure _____
Stroke _____
Bleeding/clotting disorder _____
Asthma/COPD _____
Anxiety _____
Other: _____

Social History

Please fill ALL of the Following Information:

Tobacco Use:

Cigarettes ☐ Never ☐ Quit Date: _____
☐ Current Smoker: packs/day_____ # of years _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ Yes ☐ No
Passive Smoke Exposure? ☐ Yes ☐ No

Alcohol Use:

Do you drink alcohol? ☐ Yes ☐ No
Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Caffeine Intake: ☐ None ☐ Coffee/tea/soda_____ cups/day

Drug Use:

Do you use any recreational drugs? ☐ Yes ☐ No
Illicit drugs used in lifetime: _____
Have you ever used needle to inject drugs? ☐ Yes ☐ No

Pt. Name: _____

Weight: Are you satisfied with your weight? ☐ Yes ☐ No
Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor
Are you on a specialized diet? ☐ Yes ☐ No
If yes, please specify: _____

Exercise: Do you exercise regularly? ☐ Yes ☐ No
What kind of exercise? _____
How long (minutes)? _____ How often? _____
If you do not exercise, why? _____

Sexual Activity:
Sexually active: ☐ Yes ☐ No
If yes, protected sex? ☐ Yes ☐ No
Sexual Orientation: _____
Number of sex partner(s)*in lifetime*: _____
Birth control method: _____ ☐ none needed
Have you ever had any sexually transmitted diseases (STDs)?
☐ Yes ☐ No
Are you interested in being screened for sexually transmitted diseases? ☐ Yes ☐ No

Women's Health History
# of pregnancies _____
# of deliveries _____
# of abortions _____
# of miscarriages _____
# of ectopic pregnancies _____
Age at start of periods_____ Age at end of periods_____
Date of last period: _____

General Health:
Are all your vaccinations up to date? ☐ Yes ☐ No
Your general stress level: None Mild Moderate High
Are you hard of hearing/deaf in 1 or both ears? ☐ Yes ☐ No
Are you legally blind in 1 or both eyes? ☐ Yes ☐ No
Do you perform monthly self-exam? ☐ Yes ☐ No
Have you been hospitalized or to the emergency room in the last 12 months? ☐ Yes ☐ No
If yes, when/what for? _____

Socioeconomics:
Education Level:
<8th 8th 9th 10th 11th 12th 2yr degree 4yr degree post grad
Are you currently employed? ☐ Yes ☐ No
If not, what are the barriers: _____
Do you need assistance finding employment? ☐ Yes ☐ No
Occupation: _____
Employer: _____
Does your income provide enough to meet your basic needs?
☐ Yes ☐ No
Number of children/ages: _____

Care Management:
Do you have a current Advanced Directive? ☐ Yes ☐ No
Would you like to complete an Advanced Directive? ☐ Yes ☐ No
Are you able to care for yourself? ☐ Yes ☐ No
Do you live alone? ☐ Yes ☐ No
Are you in need of housing? ☐ Yes ☐ No
Do you feel safe in your current environment? ☐ Yes ☐ No
Is there someone you would like to make decisions for you if you were unable to? ☐ Yes ☐ No
If yes, who? _____
Do you have enough food to meet your basic needs? ☐ Yes ☐ No
Need assistance with water, electricity, gas, ext.? ☐ Yes ☐ No
Need assistance with transportation? ☐ Yes ☐ No
Need assistance applying for Medicare or Medicaid? ☐ Yes ☐ No
Are guns present in the home? ☐ Yes ☐ No
If yes, are they locked? ☐ Yes ☐ No
Are there smoke alarms in the home? ☐ Yes ☐ No
Seat belt used routinely? ☐ Yes ☐ No
Sunscreen used routinely? ☐ Yes ☐ No
Animal exposure? ☐ Yes ☐ No
Rec/sport/hobbies: _____

TUELLER COUNSELING SERVICES
UNIFIED HEALTHCARE OF IDAHO

For Unified Staff Only:

Height: _____
Weight: _____
BP: _____/_____
BPM: _____
O² Level: _____
Temp: _____°F
Reason for Visit: _____
_____
Extra Notes: _____
_____
_____
_____