TUELLER COUNSELING SERVICES
UNIFIED HEALTHCARE OF IDAHO

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? (Please circle all that apply):
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 Name (Last): (First):
Phone Number: Relationship to Patient: ☐ Guardian
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 agree to allow my child to be treated by the providers at Unified HealthCare of Idaho.

Patient (or Responsible Party) Signature: Date:

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.

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 (or Responsible Party) Signature: Date:

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UNIFIED
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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: _____

Child Health History

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. Thank you.

Patient Name: Date of Birth:
Mother's Name: Father's Name: Other parent's name:
Who does your child live with?

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

Main reason for today's visit:
Other concerns:

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

If you child is *eleven years old or older*, please have them answer the following questions:

Over the *last seven days*, 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
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Poor appetite, weight loss, or overeating	0	1	2	3
Feeling tired, or having little energy	0	1	2	3
Feeling bad about yourself- feeling like you are a failure, or that you have let you or your family down	0	1	2	3
Trouble concentrating on things like school work, reading, or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed *Or the opposite* Being so fidgety or restless and 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 if for you to do your homework, take care of things at home, or get along with other people? ☐ not difficult at all ☐ somewhat difficult ☐ very difficult ☐ extremely difficult

Social History & Lifestyle

Daycare or Nanny ☐ Yes ☐ No School: Grade:
Any problems at home/school/daycare (*i.e. learning, behavioral etc.)*?
Who lives at home with your child?
Are there any pets in the home ☐ Yes ☐ No If yes, what type:
Diet (*please describe)*:
Exercise or Activities
Type: Number of days per week:
Does anyone smoke in the home? ☐ Yes ☐ No
If your child does not use a booster seat while driving, do they use their seatbelt? ☐ Yes ☐ No
Does your child wear a helmet while riding their bike? ☐ Yes ☐ No
Are there guns in your home? ☐ Yes ☐ No If yes, are they unloaded and locked away? ☐ Yes ☐ No
Is there any history of abuse in your child's home or life (physical, sexual, emotional, neglect)? ☐ Yes ☐ No

If yes, please specify:

Health Maintenance & Prevention

When was the last time your child had a well-child exam? Went to the dentist?

Female Health

Has your child started her period? ☐ Yes ☐ No If yes, what age?

Has your child had a Pap smear? ☐ Yes ☐ No If yes, when? Result: ☐ Normal ☐ Abnormal

Immunizations

Are your child's immunizations current? ☐ Yes ☐ No

Personal Medical History

Pregnancy complications: Delivery complications:

Delivery method: ☐ Vaginal ☐ C-Section Birth Weight: Multiple births (twins): ☐ Yes ☐ No

Has your *child* ever had any problems with the following (*if yes, please explain*):

☐ Alcohol or substance abuse:
☐ Cancer:
☐ Blood:
☐ Digestion:
☐ Ear, nose, throat, eyes:
☐ ER Visits: Type: Date:
☐ Heart or blood vessels:
☐ Hospitalizations: Type: Date:
☐ Infectious diseases:
☐ Kidneys or bladder:
☐ Learning disabilities:
☐ Lungs:
☐ Metabolism (diabetes, thyroid, etc.):
☐ Muscle, joint, bones:
☐ Nerves and brain:
☐ Skin and hair:
☐ Sleep:
☐ Social, mental or emotional health:
☐ Surgeries: Type: Date:
☐ Female health (menstrual problems, etc.):
☐ Male health (testicular lump/pain):
☐ Other:

Family Medical History Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism
Autism
Cancer, specify type
Heart disease
Depression/suicide
Genetic disorders
Diabetes
Kidney Disease
High cholesterol
High blood pressure
HIV
Stroke
Skin cancer
Bleeding/clotting disorder
Asthma/COPD
Anxiety

Any other condition that two or more relatives have, or not mentioned?

Would you or your family be interested in family counseling, individual counseling, group therapy, drug and alcohol counseling, or parenting classes?

☐ Yes ☐ No

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