CORE MEDICINE
URGENT CARE & FAMILY PRACTICE

Family Practice Patient Registration

Core Medicine of Idaho welcomes you to our Urgent Care and Family Practice. Here at Core, our goal is to provide you with exceptional patient care.

In order to succeed, our goal is to provide an outstanding visit to our office. We ask that you come prepared for your new patient appointment.

Please provide the following while checking in for your appointment:

- Entire new patient paperwork packet completed
- Updated Medication List
- ID, Insurance card(s), Prescription Card
- Copay/Payment at the time of service

Please arrive 30 mins early to your appointment, to ensure that we can complete all necessary steps to make sure you get properly checked in.

Thank you for understanding. We look forward to you coming to Core Medicine of Idaho.

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PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Patient's Legal Name: (Last) ____________________ (First) ____________________ (MI) _______
Preferred Full Name (if different from above): ______________________________
Address: ____
City, State, Zip: ____
Home Phone Number (landline): ____________________ Cell: ____________________
E-mail Address: ____ Date of Birth: ____________
Gender Identity: ☐Male ☐Female How did you hear about us? ____________________________
Race: ☐American Indian/Alaska Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White ☐Hispanic ☐Choose Not to Disclose ☐Other not listed ____________________
Ethnicity: ☐Hispanic orLatino ☐Not Hispanic or Latino ☐Choose not to Disclose
Preferred Language: ☐English ☐Spanish ☐ASL ☐Other __________
Patient's Social Security Number: __________________________

RESPONSIBLE PARTY INFORMATION (if not self) information used for patient balance statement

Responsible Party: ☐Another Patient ☐Guarantor ☐Self Check here if address and telephone information is same as patient ☐
Responsible Party Name: (Last) ________________ (First) ____________________ (MI) _________
Date of Birth: MM____/DD_____/YYYY_______ Sex: ☐Male ☐Female
Responsible Party Social Security Number: _______-______-________ Phone Number: ____________
Address: ____
City, State, Zip: ____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check in.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: (Last) ____________________ (First)__________________________
Phone Number: __________________________________ Do you have a living will? ☐Yes ☐No
Emergency Contact Relationship to patient: ______________________________ ☐ Guardian
Address: ____
City, State, ZIP: ____
Home Phone: _______________________ Work Phone: _____________________ Etx. _________

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

I hereby consent and give my permission to the doctor(s) (and the doctor's assistants or designated replacement) to administer and perform such procedures or treatment upon me as the doctor has suggested and that I have agreed to.

Signature of Patient or Personal Representative: ____
Date:________________
Printed Name of Patient of Personal Representative: ____________________________
Relationship to Patient _____________

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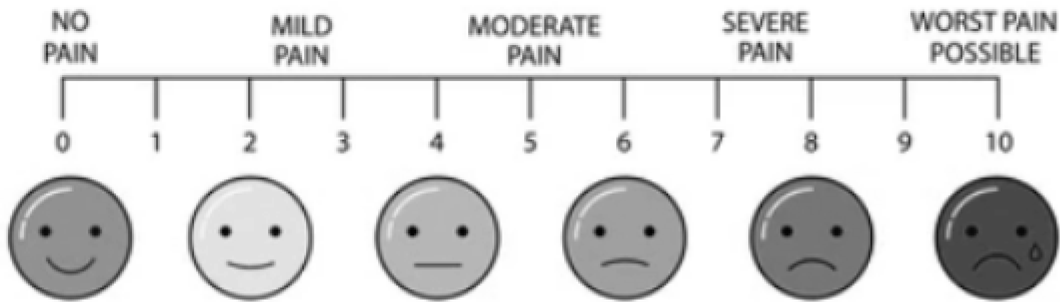
Brief Medical History



Please describe what brought you in to see the doctor today:

Was this an injury/accident? Y / N Work Related? Y / N

Have you notified your employer about this injury? Y / N Date of Injury ____________

Allergies	Reaction

Medication	Dose	Reason	Medication	Dose	Reason

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If Patient Has Diabetes:

Blood sugar this morning ____________________ Last HbA1c ________________
When was the last time your HbA1c was tested? (Month/Year) _______________________

Perinatal History - For Pediatric Patients Only

Please complete if patient is a child under the age of 18
Gestation: Was the child born prematurely? Y / N
How old was the child when they began to:
Cruise _______ Crawl _______ Walk _______ Talk _______
Has there been any developmental delays? Y / N
Are all immunizations up to date? Y / N

Additional History

Please list any other issues the doctor should be aware of:

Social History: Frequency/Quantity:

Exercise	
Working	
Alcohol	
Tobacco	
Marijuana	
Narcotics	
Safe At Home/Work? Can we help you today?	

Family History: Who:

Diabetes	
Cancer	
Heart Disease	
Stroke	
Autoimmune Disease	
Gout	
COPD/ Asthma	
Other	

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GENERAL	**GENITOURINARY**	**MUSCULOSKELETAL**
Fatigue	Leaking urine	Stiffness out of bed
Unexpected weight gain/loss	Urinary Tract Infection	Joint Stiffness
Fever / chills	Blood in urine	Leg Swelling
Dehydration	Excessive urination	Back pain
	Difficulty Urinating	Gout

ENDOCRINE	**GASTROINTESTINAL**	**NEUROLOGY**
Heat / Cold intolerance	Heartburn	Headaches / Dizziness
Exhaustion	Bloating	Tingling or numbness
Dry Skin	Diarrhea	Steady gait
	Constipation	Frequent falls
	Abdominal Pain	
	Nausea/Vomiting	

EARS, NOSE, THROAT	**DERMATOLOGIC**	**RESPIRATORY / HEART**
Difficulty Swallowing	Rash	Racing heartbeat
Ear infection / Sinus infection	Darkened mole/Suspicious mole	Chest pains
Bloody nose	Itchy feet	History of blood clots
Hearing Changes	Bug Bites	Breath Shortness/Breathing Difficulty
EYES	Cuts	Asthma
Blurred vision	Wound	Pneumonia
Glasses / Contacts	**LYMPHATIC**	Cough
Eye Pain	Swollen lymph nodes	Fainting/Light-Headedness
Vision Changes		Unexplained Weight Gain
		Exercise Difficulty/Intolerance

Please explain the above circled symptoms: ____

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____

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Medical Conditions

Do you have a history of any of the medical problems listed?
CIRCLE all that apply:

AIDS/HIV
Alcoholism
Anemia
Asthma
Bipolar Disorder
Bleeding Disorders
Blood Clots/DVT
Cancer ____________________
Cerebral Palsy
Chemical Dependency
Cellulitis
Crohn's Disease
Coronary Artery
Cirrhosis of the Liver
Clotting Disorder
COPD/Pulmonary Disease
Depression/Anxiety
Diabetes/Pre-diabetes
Emphysema
Fibromyalgia GERD/Peptic Ulcers
Gluten Intolerance
Gout
Heart Disease
Heart Attack
Hemophilia Hepatitis A / B / C

High Blood Pressure
High Cholesterol
Immune Disorder
Irritable Bowel Disease
Kidney Disease
Leg/Foot Ulcer
Low Blood Pressure
Liver Disease
Lupus
MRSA- Infection
Neuropathy
Multiple Sclerosis
Opiate Dependency
Osteoarthritis Psoriasis
Psychiatric Illness
Raynoaud's Disease
Respiratory Disease
Rheumatoid Arthritis
Spine injury/Deformity
STD
Stroke
Thyroid Disease
Urinary Tract Infections
Venereal Disease
Other_______________

Surgical History & Hospitalization History

Please list all surgeries and any recent hospitalizations with dates.

Have you received any vaccination within the last 12 months? Y / N
List Vaccinations Received: ____

Do you have an Advanced Care Plan / Living Will? Y / N

Have you seen other Providers/Specialties? Y/N Who/What For? ______________________________

Any recent Antibiotic use? Y/N If YES, when? ______________________________________

PATIENT FINANCIAL & PAYMENT POLICY

Thank you for choosing **CORE** as your medical care provider. We are committed to providing you with high quality and satisfactory healthcare. Please carefully read and sign this form to acknowledge your responsibility and understanding of our payment and financial policy.

Patient Responsibility: The patient or patient's guardian, if a minor (under the age of 18) is responsible for the payment for treatment and care. **Payment is due at time of service for co-pays, coinsurance and deductibles.** This arrangement is part of our contract with your insurance company. Failure on our part to collect from patients can be considered fraud. Any remaining balance will be billed to you and must be paid in full 30 days after receiving your statement. We ask to have a Card of File for any overdue, or unpaid balances. These will be charged to the card 30 days after the claim is turned over to patient responsibility.

Self Pay Accounts / Patients Without Insurance: We accept patients without insurance. **Payment is due, in-full, at the time services are rendered.** Our best efforts will be made by the clinic to estimate the total charges for your visit. Payment for basic visits are required up front. Any additional diagnostic testing, procedures, medications administered, and/or supplies/equipment used during the visit will be due, in-full, upon discharge. If you do not have insurance and wish to pay for your service at time of visit in full we offer a 15% discount.

Insurance(s): It is your responsibility to provide us with your most **current** insurance card(s) and billing information. It is also your responsibility to know your insurance benefits and pay any remaining portion due after insurance processes your claim. All non covered services are your responsibility. If you have more than one insurance policy we will file with your secondary insurance. To do this, we will need to know which plan is primary and which plan(s) is secondary along with a copy of both your primary and secondary insurance cards.

Durable Medical Equipment (DME): These supplies are not always covered by many insurance companies. We collect in full for all products and services rendered.

Payment Plans: Payment plan options are reviewed on a case by case basis by management.
Care Credit: We recommend CareCredit to help with financing your medical services.

Workers Compensation / Automotive Accident: You are responsible for ensuring that your employer submits a "First Report of Injury form or illness". If your insurance company denies the claim because your employer failed to file the notice, all service charges will become your responsibility. **Automotive Accident**: We will bill your auto policy in the event of an auto accident. If someone else is responsible for the accident, we will not bill his or her insurance. You will be responsible for our bill and you will need to seek reimbursement from the other party.

Medical Records / Forms: We will provide a copy of your medical records once at no cost, per course of treatment, upon receipt of a signed Medical Records Release. There will be a charge of $50.00 for additional requests and must be paid at the time the records are released. There will be a $50.00 fee for any FMLA forms to be completed.

Refunds: Any refunds due to patients will only be paid after insurance processes claim and can take up to 60 days after insurance payment is received and posted to your account.

Core Medicine uses a third party company 3M Solutions, LLC to bill your insurance company on your behalf and Bonneville Collections, LLC to collect on accounts that are past due. Returned checks and balances older than 90 days are subject to collection fees. We require 24 hours notice for appointment cancellations. Failure to give a 24 hour notice will result in a $50.00 fee.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance, copay, or any service(s) deemed as a "non covered benefit" by my insurance company. I understand that failure to pay outstanding balances within 90 days of receiving my first statement will result in the submission of my account to an outside collection agency.

Patient Signature: ______________________________ Date: ______________

Family Practice- Late Cancellation & No Show Policy

LATE CANCELLATION

I understand it is my responsibility to notify Core Medicine of Idaho more than **24 hours before my scheduled appointment time** if I need to cancel my appointment. I may cancel my appointment via phone call to the office at (208) 508-0345.

Canceling an appointment within the 24 hour window is considered a "late cancellation" and is subject to a $50 fee.

NO-SHOW

Failure to show up for my scheduled appointment is considered a "no-show" and will result in a $50 fee. Three (3) consecutive no-shows may result in discharge from the practice.

It is at the discretion of the Practice Manager to determine exceptions to these fees on a case-by-case basis. As such, we understand that emergencies happen; however, it is important that all our patients respect the providers at Core Medicine of Idaho and everyone's time. If you late cancel or no-show your appointment, it takes that spot away from another patient waiting to get in to be seen.

Patient Signature: ______________________________ Date: _______________

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Notice of Privacy Practice

I understand that, under the Health Insurance and Portability & Accountability Act of 1996 (HIPAA), I have certain rights regarding the protected health information. I understand that this information can and will be used to:

- Conduct, Plan and Direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Persons Authorized to Access My Information

1. Name / Relationship: ____
2. Name / Relationship: ____
3. Name / Relationship: ____

Late Policy

Existing patients have a check in time of 15 minutes prior to appointment with the doctor. New patients have a check in time of 30 minutes, prior to appointment with the doctor. Anything past 10 minutes, will be considered late and will be canceled & rescheduled.

Treatment Consent

I hereby consent and give my permission to the doctor(s) (and the doctor's assistants or designated replacement to administer and perform such procedures or treatment upon me as the doctor has suggested and that I have agreed to.

Medical Research Disclosure

Core Medicine of Idaho participates in medical research opportunities. As a patient you may be called in the event one of our physicians identifies a trial you may qualify for. You are not required to participate in medical research as a patient of Core Medicine of Idaho.

Patient Signature: ____________________________ Date: ____________