

Dear Patient,

Welcome to Marimn Health! We are happy to serve you as a new patient. To make your visit with us more pleasant, please complete the registration information. We do require that you bring in the necessary items listed below so we are able to register you in our practice.

All patients must present the following:

- Picture ID
- Current medical/dental insurance eligibility cards, including Medicaid and Medicare

In order to establish eligibility for Indian Health Services, Native American applicants must also present the following:

- Tribal Enrollment Card or Certificate of Indian Blood
- If a descendant, a letter of descendency from your affiliated tribe or a birth certificate and a copy of parents' tribal information

To establish eligibility for our Sliding Fee Program, please bring a copy of your most recent tax return and documentation of your place of residence.

Patients are responsible to pay in full for services received unless Marimn Health is provided appropriate documentation establishing Indian Health Service and/or the Sliding Fee Program. We expect payment at time of service of any co-pays, deductibles, and co-insurance.

It is important that you provide your signature at the bottom of the first page, the acknowledgement of receipt, and the self-determination sections.

Thank you for your cooperation,

Marimn Health
First Impressions Department

Last Updated: 11/2017



Patient Information

Patient Name: _____
(Last) (First) (Middle)

Gender (at birth):

- Male
 Female

Patient Address: _____
(P.O. Box) (Street Address)

(City) (State) (Zip)

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email: _____

Preferred Contact Method: Home Phone Cell Phone Text Message Email

Date of Birth: ____ / ____ / ____ Social Security Number: _____ - _____ - _____

Employer Name: _____ Phone: (_____) _____ - _____

Emergency Contact: _____ Phone: (_____) _____ - _____

Relationship to patient: _____

Mother's Name: _____ Phone: (_____) _____ - _____

Father's Name: _____ Phone: (_____) _____ - _____

Race: American Indian Caucasian Asian African American Other **Veteran:** YES NO

Are you a member or descendant of a Federally Recognized Tribe? Yes No Tribe Name _____

Is this visit due to an accident or injury while at your work place? Yes No

Primary Insurance: _____ Medical Dental Rx

Secondary Insurance: _____ Medical Dental Rx

*If you have insurance coverage, it must be billed before Indian Health funds are applied. As a courtesy, we will bill your insurance for services rendered at Marimn Health. The patient or legal guardian is responsible for payment of all services not covered by Indian Health or by your insurance.

*I AUTHORIZE MARIMN HEALTH TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICIAN AND CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. STATEMENTS MAY BE SENT AS A COURTESY BUT PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE. PAYMENT IN FULL MAY BE DEMANDED AT ANY TIME.

*I REQUEST AND CONSENT TO TREATMENT AT MARIMN HEALTH, INCLUDING MEDICAL, DENTAL, COUNSELING, SUBSTANCE ABUSE, PHARMACY, AND ANY OTHER SERVICE OFFERED AT THE CLINIC OR WELLNESS CENTER. FURTHERMORE, I AUTHORIZE MY PROVIDER AND ANY OTHER PROVIDER WHO MAY ATTEND TO ME, THEIR ASSISTANTS, NURSES, AND ANY OTHER IN-HOUSE STAFF TO PROVIDE THE SERVICES DEEMED NECESSARY BY MY PROVIDER.

*IN CONSENTING TO TREATMENT, I UNDERSTAND THAT RESULTS OF MEDICAL TREATMENT VARY AND I HAVE NOT BEEN GUARANTEED SPECIFIC RESULTS.

SIGNATURE: _____ DATE: _____

Front Desk Staff Only: MR #: _____ Initials: _____



Notice of Privacy Practices

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

We may use and disclose your personal health information:

- For treatment activities, both at Marimn Health and to referring doctors
- To bill for your services
- To conduct our day-to-day business and service operations
- Marimn Health participates in the Idaho Health Data Exchange where other health care providers involved in your care may access your health information.
- To give appointment reminders via phone and mail
- To provide interpretation services, if needed
- To inform you of helpful health-related services and treatment alternatives provided that we do not receive payment for these communications
- To keep friends, family members or personal representatives who are involved in your care or payment for your care informed, as long as you have agreed to this disclosure.
- To funding agencies as required by law and who support your care such as Indian Health Service, Bureau of Primary Health Care, Purchased and Referred Care, Veterans Administration, etc.
- To avert a serious threat to health or safety
- For worker's compensation claims
- For public health protection interventions as required by law
- As required for lawsuits and legal disputes
- To law enforcement as required by law
- To coroners, health examiners and funeral directors
- To national security, intelligence agencies, and protective services as required by law
- To certain specialized government functions, e.g. military, prisons, etc.
- Other uses and disclosures not included in our *Notice of Privacy Practices* will be made only with your written authorization

Your Rights:

- You have a right to be informed of our privacy practices, and to request a copy of the complete *Notice of Privacy Practices* handout
- To inspect and copy your personal health information. You have the right to request an electronic or paper copy of your health information records
- To request amendment of your health information records
- To receive an accounting of disclosures of your health information
- To request restrictions on the uses or disclosures of your health information
- To receive confidential communications by alternative means or at alternative locations
- To receive notification if there is an unauthorized disclosure of your protected health information
- To choose someone to act for you
- To choose to opt out of having your health information shared with the Idaho Health Data Exchange
- To file a complaint without threat of retaliation if you believe your privacy rights have been violated. For assistance, please contact the Quality Improvement Coordinator at (208)686-1931 ext.219.

PATIENT ACKNOWLEDGEMENT OF RECEIPT:

I, _____, hereby acknowledge that I have read and understand this Notice of Privacy Practices.

SIGNATURE: _____ **Date:** _____

MR #: _____



Patient Self-Determination

The patient Self-Determination Act is a law passed in 1990. It states that clinics that get Medicare or Medicaid funding are required to offer patients information on the Advanced Directive, such as a living will or durable power of attorney, and we are required to ask if a patient already has an Advanced Directive in place.

I do I don't **currently have an Advanced Directive in place.**

If you would like more information on Advanced Directive, please ask your provider for an information packet.

Demographic Information

The following information helps Marimn Health with funding from several grant sources which better enables us to provide quality care within our communities. We would greatly appreciate it if you would take the time to complete the information requested.

Please circle the answer that best describes you and your family.

Family Size: 1 2 3 4 5 6 7 8 Other: _____

Family Income: Under \$13,000 \$13,000-\$20,000 \$20,000-\$30,000

 \$30,000-\$40,000 \$40,000-\$50,000 \$50,000-\$60,000

 \$60,000-\$70,000 \$70,000-\$80,000 Over \$80,000

Our funding agreements with the federal government require that we report on the ethnic consideration of Hispanic or Non-Hispanic heritage. If you consider yourself to be Hispanic heritage, please circle "Hispanic". If not, please circle "Non-Hispanic".

I Consider Myself Primarily: Hispanic Non-Hispanic

SIGNATURE: _____ **DATE:** _____

MR #: _____

