BENEWAH MEDICAL CENTER
Po Box 388
Plummer, Idaho 83851
208-686-1931

WELLNESS CENTER
Po Box 700
Plummer, Idaho 83851
208-686-9355

Dear Patient,

Welcome to Benewah Medical & Wellness Center. 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 (CIB)
- If a descendant, a letter of descendancy 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 the Benewah Medical Center is provided appropriate documentation establishing Indian Health Service and/or the Sliding Fee Program. The Medical Center expects 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,

Benewah Medical & Wellness Center
First Impressions Department

BENEWAH MEDICAL CENTER
Po Box 388
Plummer, Idaho 83851
208-686-1931

WELLNESS CENTER
Po Box 700
Plummer, Idaho 83851
208-686-9355

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

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

Gender (at birth):
□ Male
□ Female

_____
(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: (____) ____ - ____ Relation 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 Benewah Medical Center. The patient or legal guardian is responsible for payment of all services not covered by Indian Health or by your insurance.

I AUTHORIZE BENEWAH MEDICAL CENTER TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICAN 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 BENEWAH MEDICAL CENTER, 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 #: _____ □ Chart Notes □ EHR □ Carepoint Initials: _____

BENEWAH MEDICAL CENTER
Po Box 388
Plummer, Idaho 83851
208-686-1931

WELLNESS CENTER
Po Box 700
Plummer, Idaho 83851
208-686-9355

NOTICE OF PRIVACY PRACTICES

We understand your health information is personal!

We may use and disclose your personal health information:

- For treatment activities, both at BMC and to referring doctors
- BMC participates in the Idaho Health Data Exchange where other health care providers involved in your care may access your health information.
- For payment processes
- To conduct our day-to-day business and service operations
- 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 or family members who are involved in your care informed
- For quality improvement activities
- To funding agencies as required by law and who support your care such as Indian Health Service, Bureau of Primary Health Care, Contract Health Services, 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 correctional institutions if you are an inmate

Your Rights:

- You have a right to be informed of our privacy practices
- To inspect and copy your personal health information
- To amend your health information records
- To receive an accounting of disclosures of your health information
- To request restrictions on your health information
- To receive personal confidential communication requests
- To receive a paper or electronic copy of the complete Notice of Privacy document
- To receive notification if there is an unauthorized disclosure of your protected health information
- To choose someone to act for you
- You may choose to opt out of having your health information shared with the Idaho Health Data Exchange by completing the IHDE "Request to Restrict Disclosure of Health Information, the fax or mail to IHDE (Information available at the Front Desk)
- To file a complaint if you believe your privacy rights have been violated. For assistance, please contact the Quality Improvement Coordinator.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

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

SIGNATURE: _____ **DATE**: _____

MR #:_____

BENEWAH MEDICAL CENTER
Po Box 388
Plummer, Idaho 83851
208-686-1931

WELLNESS CENTER
Po Box 700
Plummer, Idaho 83851
208-686-9355

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 to receive more information on Advanced Directive, please ask your provider for an information packet.

The following information helps the Benewah Medical Center 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**: _____