Dear Patient,

Welcome! Marimn Health is recognized as a Patient Centered Medical Home. A Medical Home provides services that are patient-centered. The Medical Home acts as the primary point of care for the patient and the relationship between the patient and his/her family. 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 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 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

MARIMNHEALTH
COEUR D'ALENE TRIBE

Please select the location(s) you are requesting below:

☐Medical ☐Dental ☐Behavioral Health ☐Optical ☐Chiropractic

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____

Date of Birth: ____/____/____ Gender (at birth): ☐Male ☐ Female ☐ Choose Not to Disclose

Social Security # (SSN): _____ Email Address: _____

Home Phone #: _____ Cell Phone #: _____

Notification Preference: Phone Email Text Patient Portal

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Mailing Address:

Address: _____ City: _____ State: _____ Zip: _____

Physical address (*if different from mailing address)*:

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____

Guarantor Information (*Complete **ONLY** if patient is a minor)*:

Parent/Guardian Name: _____ Relationship: _____ Date of Birth: _____

Phone #:

Insurance Information:

Primary Insurance: _____ Policy ID #: _____ Group#: _____

Name of Policy Holder: _____ DOB: ____/____/____ Policy Holder SSN #: _____

Secondary Insurance: _____ Policy ID #: _____ Group#: _____

Name of Policy Holder: _____ DOB: ____/____/____ Policy Holder SSN #: _____

*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 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 MARIMN HEALTH, INCLUDING MEDICAL, DENTAL, COUNSELING, SUBSTANCE ABUSE, PHARMACY, AND ANY OTHER SERVICE OFFERED AT THE CLINIC OR WELLNESS CENTER. THIS FACILITY PROVIDES COMPREHENSIVE AND INTEGRATED HEALTH AND WELLNESS SERVICES AND USES A SHARED MEDICAL RECORD. 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 RESULT

SIGNATURE: _____ Date: _____

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

MARIMNHEALTH
COEUR D'ALENE TRIBE

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.

Homeless Status: □ Doubling Up □ Not Homeless □ Shelter □ Street □ Transitional □ Unknown/Unreported
Migrant Worker Status: □ Migrant □ Not a Farmworker □ Not a Migrant Worker □ Seasonal
Language Barrier: □ Yes □ No
Race: □ American Indian □Caucasian □Asian □African American □ Other_____
Veteran: □ Yes □ No
I Consider Myself Primarily: □Hispanic □Non-Hispanic □Other □Decline to Specify
Are you a member or descendant of a Federally Recognized Tribe? □ Yes □ No Tribe Name: _____
****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 descendancy from your affiliated tribe or a birth certificate and a copy of parents' tribal information*

Gender Identity:

□Female □Male □ Female-to-Male □Male-to-Female □Choose Not to Disclose □Other: _____

Sexual Orientation:

□ Straight □ Gay □ Bisexual □Choose Not to Disclose □ Other_____

Pronouns (ex. she, them, he, they, etc.): _____

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

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.

SIGNATURE: _____Date: _____

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

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

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.

THIS NOTICE IS EFFECTIVE: 02/20/2026

Overview:

For the purpose of this Notice, "we, our, us" means Marimn Health. This notice provides information about the use and disclosure of your protected health information (PHI) by Marimn Health.

This Notice:

- Describes your rights and our responsibilities regarding your health information.
- Explains how we may use and share your health information.
- Informs you about additional privacy protections required by law, including special protections for Substance Use Disorder (SUD) records under 42 CFR Part 2.
- Tells you how we will communicate any updates to this Notice.

Who will follow this Notice:

This Notice applies to all staff, healthcare providers, volunteers, students, workforce trainees and departments of Marimn Health, as well as affiliated entities and business associates who assist with your care or health care operations.

OCHIN Organized Health Care Arrangement:

Marimn Health is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Marimn Health, OCHIN supplies information technology and related services to Marimn Health and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by Marimn Health with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed. If the information includes Substance Use Disorder (SUD) records protected under 42 CFR Part 2, these records may only be disclosed to OCHIN participants with your specific written consent, unless otherwise permitted by law.

MRN: _____

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

Uses and disclosures permitted without your authorization:

- Treatment: We may use or disclose your health information to provide, coordinate, or manage your healthcare. Certain Substance Use Disorder (SUD) records are subject to stricter federal protections and may be used or disclosed for treatment, payment, or health care operations only if you have provided a specific written consent under 42 CFR Part 2.
- Payment: We may use or disclose your health information to obtain payment for services provided to you.
- Health Care Operations: We may use or disclose your health information for certain activities that are necessary for health care operations.

We will obtain a written authorization from you before using or disclosing your protected health information for any purpose other than that summarized above. You may revoke your authorization at any time by submitting a written notice to the Health Information Management Department. The revocation will not affect disclosures that have already been made but will stop future disclosures.

Other Uses or Disclosures:

- Appointment Reminders and Treatment Alternatives: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services.
- Business Associates: We may disclose your health information to business associates with whom we contract to provide services.
- Coroners, Medical Examiners and Funeral Directors: We may disclose health information to a coroner, medical examiner or funeral director to assist them in carrying out their duties.
- Health Oversight: We may disclose health information to a health oversight agency or public health authority authorized by law to investigate or oversee health provider conduct, compliance, or conditions.
- Idaho Health Data Exchange (IHDE): Marimn Health shares information through the IHDE for treatment, payment, and health care operations. To opt out, contact IHDE directly at https://idahohde.org/patients/faqs/.
- Incidental Uses and Disclosures: There are certain uses or disclosures of your information that may occur while we are providing service to you or conducting our business.
- Interpreters: We may use the services of an interpreter that may require use or disclosure of your personal health information.
- Law Enforcement: We may share information with law enforcement to report injuries, prevent serious threats, locate individuals, support national security, or respond to crimes or emergencies.
- Legal Proceedings: We may disclose health information to attorneys or courts in response to a subpoena, discovery request or other lawful process. This does not apply to SUD records protected under 42 CFR Part 2, which cannot be disclosed in any legal proceeding without your written consent or a court order.
- Military: If you are a member of the armed forces, we may disclose information about you as required by military command authorities or to the Department of Veterans Affairs.
- Organ Procurement Organizations: We may disclose health information to organizations that handle organ, eye or tissue donation or transplantation.
- Public Health Activities: We may disclose your health information with authorized public health or other governmental authorities authorized by law to receive information for the purpose of preventing or controlling disease, injury, disability, reporting neglect or abuse, or for purposes related to the quality, safety, or effectiveness of regulated products or services.
- Required by Law: We may use or disclose your protected health information to the extent the law requires it including Worker's Compensation.
- Research: We may use or disclose information about you for research projects. Research projects must go through a special process that protects the confidentiality of your information.

MRN: _____

Uses and Disclosures When You Have the Opportunity to Object:

- Disclosure and Notification of Family, Friends or Others Involved in Your Care: Unless you object, we may share your health information with a family member, caregiver, or other person involved in your care or payment.
- Disclosure for Disaster Relief Purposes: We may disclose your location and general condition with public or private entities (such as FEMA or the Red Cross) authorized by law or their charters to assist in disaster relief efforts. Unless required by law, we will obtain your written permission when feasible before making these disclosures.
- Fundraising: We may disclose health information to a business associate or Marimn Health-related foundation for the purpose of raising funds for the organization. We will always provide you with a clear way to opt out of future communications. Choosing to opt out will not affect your care, treatment, or benefits. Please see "Uses and Disclosures Requiring Your Written Authorization" for special protections that apply to SUD records under 42 CFR Part 2.

Uses and Disclosures Requiring Your Written Authorization:

The "Opportunity to Object" does not apply to the following disclosures. A separate written authorization from you is required:

- Psychotherapy Notes: Psychotherapy notes have special protections under federal law, specifically under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at 45 CFR § 164.508(a)(2). We generally need your written permission to share psychotherapy notes except as permitted by law (e.g., for your treatment by the originator, to defend ourselves in a legal action, HHS investigations, or as otherwise required by law).
- Substance Use Disorder (42 CFR Part 2): SUD records are subject to stricter confidentiality rules under 42 CFR Part 2. These records cannot be used in civil, criminal, administrative, or legislative proceedings against you without your written consent or a court order.

Example: We cannot disclose SUD treatment records to law enforcement without proper authorization.

- Fundraising and SUD Records: If Marimn Health intends to use or disclose records subject to 42 CFR Part 2 for fundraising for the benefit of Marimn Health, you will first be provided a clear and conspicuous opportunity to opt out of receiving any fundraising communications. Choosing to opt out will not affect your care, treatment, or benefits.
- More Stringent Laws: If other federal or state laws are more restrictive than HIPAA (for example, 42 CFR Part 2), our practices and this Notice reflect the more stringent requirements. Where other laws permit or require disclosures, this Notice includes sufficient detail to place you on notice of those uses and disclosures.
- Redisclosure Notice: Information disclosed under HIPAA may be redisclosed by the recipient and may no longer be protected. SUD records disclosed under 42 CFR Part 2 cannot be redisclosed unless explicitly permitted by law or with your written consent.
- Genetic information, sexually transmitted diseases/HIV, and minors' health information may have additional protections under applicable law.

Your Rights:

When it comes to your health information, you have certain rights. This section explains those rights and how to exercise them:

- Access/Copies: You have the right to inspect and obtain a paper or electronic copy of your medical and billing records and other health information we maintain about you, except in limited circumstances permitted by law. To request a copy, contact the Health Information Management department at Marimn Health.

- Accounting of Disclosures (HIPAA): You may receive an accounting of certain disclosures we have made of your protected health information within the previous six (6) years from the date of the request, at no charge in a 12-month period. This will not include disclosures for treatment, payment, health care operations, disclosures you authorized, or other exclusions allowed by law.
- Accounting of Disclosures (SUD/42 CFR Part 2): If we maintain records related to your SUD treatment that are protected by 42 CFR Part 2, you may also request a list of all disclosures made with your consent for up to three (3) years before your request. This right is in addition to your HIPAA accounting right.
- Amendment: You may submit a written request to correct or amend your health information, and we will respond within 60 days. Your request must clearly state the reason you believe the amendment or correction is necessary. If we deny your request, we will provide you with a written explanation of the reason for the denial and inform you of your right to submit a statement of disagreement.
- Breach Notification - If a breach of your unsecured health information occurs, we will notify you promptly, as required by law. This includes breaches involving SUD/Part 2 records.
- Changes: If we make changes to this Notice, the revised version will be posted on our website and available at all Marimn Health locations.
- Choose Someone to Act for You - You have the right to appoint someone to make health care decisions for you or to act on your behalf regarding your health information.
- Confidential Communication: You may request we contact you by alternative means or at specific locations. We will accommodate reasonable requests.
- Restrictions: You may ask us not to use or share certain information for treatment, payment, or health care operations. We are required to agree if you paid for a service in full out-of-pocket and request that we not share information about that service with your health plan for payment or health care operations. Otherwise, we are not required to agree, but we will consider all reasonable requests.
- Paper Copy: You have the right to obtain a paper copy of this Notice at any time.

Language Access & Accessibility

We provide free language assistance services and auxiliary aids to ensure meaningful access for individuals whose primary language is not English and for individuals with disabilities. If you need this Notice or other information in another language, large print, audio, or another accessible format, please contact us using the information below.

Questions or Complaints: You may file a formal complaint or if you have questions or concerns about your privacy rights. We will not retaliate against you for filing a complaint:

- **Marimn Health Privacy Information Manager:**
- Phone: (208) 686-1931 ext. 1149
- Email: Compliance@marimnhealth.org
- Mailing Address: 427 12th St, Plummer, ID 83851
- **Office of Civil Rights (OCR):**
- Online: https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- Email: OCRComplaint@hhs.gov
- Mail: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201.

PATIENT ACKNOWLEDGEMENT OF RECEIPT:

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

SIGNATURE: _____ **Date:** _____

MRN: _____

Date Revised: 02/20/2026

Date Approved: 02/20/2026

HIPAA Compliance Patient Consent Form

Patient Name: _____

Date of Birth: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Mar Health reserves the right to change the privacy policy as allowed by law.
- Marimn Health has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Marimn Health may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? _____YES _____NO
May we leave a message on your answering machine at home or on your cell phone? _____YES_____NO
May we discuss your medical condition with any member of your family? _____YES _____NO
If YES, please name the members allowed:

1._____

2._____

3._____

Information to be disclosed:

☐ Medical Records
☐ Labs/X-rays
☐ Other: _____

_____

Consent Signed by:(printed): _____

Signature: _____ Date: _____

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