



Minidoka Medical Center | RHC

1308 8th Street, Suite 1 | Rupert, ID 83350 (208) 436-4322 Fax (208)436-1312

Patient Demographics

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will remain confidential.

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Physical Address \_\_\_\_\_ Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address(if different than physical) \_\_\_\_\_ Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred method of contact: Home phone Cell phone Text Email Mail

Email address \_\_\_\_\_ None

We will not use your email for solicitation. It is for communication purpose via portal only.

Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed \_\_\_ Widowed/remarried \_\_\_ Significant other \_\_\_

If minor child list name of parent / guardian \_\_\_\_\_

Parent/guarantor date of birth \_\_\_\_\_ Phone number if different \_\_\_\_\_

Patient or Parents Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to contact in case of emergency? \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Contact number for emergency, different phone number than already listed please: \_\_\_\_\_

People who can call and receive patient medical information: (for confidentiality purposes)

Table with 3 columns: Name, Relationship, Phone

Select your primary medical provider in this office

- Aaron Catmull, NP; Cameron McHan, NP; Shawna McCaffrey, NP; Brian Muir, DO; Jeff Swenson, MD; Casie Taylor, NP; Rebecca Warnick, NP

Primary Insurance Kevin Owens, MD FACP; ID Number; Name of Insured; Birth-date of Insured; Relationship to pt.; SSN of insured; Amount of deductible \$ or Co-Pay \$

ID Number; Group #; Name of Insured; Birth-date of Insured; Relationship to pt.; SSN of insured;

Secondary Insurance; Amount of deductible \$ or Co-Pay \$

I request that payment of authorized Commercial Insurance/Medicaid/Medicare/Medicare supplement benefits be made either to me, or on my behalf to Minidoka Medical Center/Rural Health Clinic for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to my insurance, or Centers for Medicare and Medicaid Services, and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE (for insurance assignment) \_\_\_\_\_ Date \_\_\_\_\_

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

**X**

**Date** \_\_\_\_\_

**Consent to Treat/Signature of patient or responsible party**

**Minidoka Medical Center | RHC**  
1308 8th St. Ste 1 | Rupert, ID 83350 P: 208- 436-4322 F: 208-436-1312

**Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Today's Date** \_\_\_\_\_

**Consent for Photograph**

I consent to allow photography of myself for identification purposes, and for purposes of improving my medical care documentation (ie: wounds, lesions, etc).

\_\_\_\_\_  
**Sign here**

**AUTHORIZATION FOR TREATMENT**

I hereby authorize, Minidoka Medical Center, and any assistants or associates that may be designated, to perform medical and hospital care to the above named patient

\_\_\_\_\_  
**Sign here**

**Privacy Practices/Discrimination and Patient Rights and Responsibilities**

I have received/or declined copy of the Notice of Privacy Practices and Patient Rights and Responsibilities. I have been provided an opportunity to review this entire document. Minidoka Memorial Hospital and Medical Center will not discriminate against a patient because of race, color, national origin, religion, ability to pay, or because a patient is covered by a program such as Medicaid or Medicare. If you feel you are a victim of discrimination you have the right to file written complaint to the Compliance Officer. Forms are available in the business office.

\_\_\_\_\_  
**Sign here**

**Consent to use of answering machine, text and/or voicemail messaging/email**

I grant permission and consent to Minidoka Medical Clinic and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, whether provided by me or obtained on its own; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address or phone number associated with me, whether provided by me or obtained on its own; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I further agree to provide updated contact information in an effort to avoid unintended disclosures of my information and I accept and acknowledge that Minidoka Medical Clinic and its agents, assignees and contractors (which may include third party debt collectors for past due obligations) will treat any email address or phone number obtained as my private email or phone number that is not accessible by unauthorized third parties. I understand that these communications may result in charges to me by my mobile service provider, and are not encrypted. I understand that communication attempts will be made to my cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided, unless notified otherwise. I understand that my refusal to provide the information described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

**Date:** \_\_\_\_\_

**Signature of Patient/Patient Representative**

# Minidoka Medical Center RHC / WorkMed

1308 8<sup>th</sup> Street Suite 1 Rupert, Idaho 83350

(P) 208.436.4322 | (F) 208.436.1312

## Family Practice

Jeffery Swenson, MD | Brian Muir, DO | Brad Wynn, DO | Cameron McHan, FNP-C | Aaron Catmull, FNP-C | Casie Taylor, FNP-C | Shawna McCaffrey, FNP | Rebecca Warnick, FNP / Charles Clair, MD

## Internal Medicine

Kevin Owens, MD- FACP | Tyson Steel, DO

# Request for Medical Records

## Provider requesting medical/health / billing records (Circle One):

Assume Patient Care as (PCP)    Follow patient jointly    Send my medical records    Patient request own medical records

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Address: \_\_\_\_\_

Where to request records from (Hospital, Clinic, or Dr. Office/s name and number/s)

Name of facility and doctor/s who provided services to you:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Reason for request:** Labs, X-Ray, Pathology, Cultures Medications and Immunizations    Office visit, ER, Hospital admit and discharge, Operative report, H&P    Cardiac studies, Pulmonary Function, Sleep Study    Billing

Other: \_\_\_\_\_

**Please send records via fax or ENCRYPTED email to the provided information below**

### ***Minidoka Medical Center, RHC***

*1308 8<sup>th</sup> Street Suite 1*

*Rupert, Idaho 83350*

*Office: (208) 436-4322    Fax: (208) 436-1312*

*mmcrhc@minidokamemorial.com (this is not a secure email, you must send encrypted file)*

**Patient Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

If you are the patient's parent or personal representative who can legally sign, please fill out and sign below.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Address, if different from patient: \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Confidentiality Notice:** This document contains confidential information belonging to the sender. This information is legally privileged and intended only for the use of the individual, or entity named above.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents, is strictly prohibited. If you have received this Fax in error, please notify the sender immediately to arrange for destruction of the documents. Thank you.

***WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RESPONSIBILITY TO:***

Treat the staff with consideration, respect and dignity.

Understand that your life-style does affect your health.

Take an active part in your health care.

Follow the agreed upon treatment plan. If you choose or are unable to follow the treatment plan, it is your responsibility to inform the Medical Provider.

Observe facility rules and regulations that are for the safety and consideration of all patients and staff.

Provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications, advance directives (living wills or durable power of attorney), and other matters relating to your healthcare.

Report whether you understand a contemplated course of action and what is expected of you.

***WHEN YOU ARE SEEN BY AN EMPLOYEE OR CONTRACTOR OF THE CLINIC, YOU HAVE THE RIGHT TO:***

Be treated with consideration, respect and dignity;

Have the confidentiality of your medical information protected, to have privacy act regulations enforced, and to have these areas of confidentiality explained to you in language you can understand;

Have privacy during case discussion, counseling & treatment;

Review your records in the presence of a healthcare professional;

Know the name and qualifications of staff providing your care;

Know your diagnosis, health problems, test results, the potential advantages and risks of treatment or procedures in language you can understand;

Expect that all services, treatment and counseling techniques will take place with your informed consent;

Participate in referral planning;

Have access to the patient comment procedure;

Refuse to participate in research.

Have another individual present in the exam room with you, if you so desire.



Minidoka Memorial Hospital, Minidoka Medical Center RHC, and Mini-Cassia Surgical and Specialty Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Minidoka Memorial Hospital does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If you need language services, come in to our Emergency Department where our staff can assist you, or call our operator at (208) 436 – 0481.

If you believe that MMH has failed to provide adequate language services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail, fax or email. If you need help filing a grievance, our Emergency Department or Business Office staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509f, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### English

ATTENTION: If you speak a language other than English, language assistance services are available to you at our Emergency Department.

### Español (Spanish)

ATENCIÓN: Si habla un idioma que no sea inglés, los servicios de asistencia lingüística están disponibles para usted en nuestro Departamento de Emergencias.

### 中文 (Chinese)

注意: 如果您使用英語以外的其他語言, 我們的急診室將為您提供語言幫助服務

### Српско-хрватски (Serbo-Croatian)

ПАЖЊА: Ако говорите неким другим језиком осим енглеског језика, службе за помоћ у вези са језиком су вам на располагању у нашем одељењу за хитне случајеве.

### 한국어 (Korean)

주의: 영어 이외의 언어를 사용하는 경우 응급실에서 언어 지원 서비스를 이용할 수 있습니다.

### नेपाली (Nepali)

ध्यान: यदि तपाईं अ English-प्रेजी बाहेक कुनै भाषा बोल्नुहुन्छ भने भाषा सहयोग सेवाहरू तपाईंलाई हाम्रो आपतकालीन विभागमा उपलब्ध छन्।

### Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói một ngôn ngữ khác tiếng Anh, các dịch vụ hỗ trợ ngôn ngữ có sẵn cho bạn tại Khoa Cấp cứu của chúng tôi.

### عربي (Arabic)

تنبيه: إذا كنت تتحدث لغة أخرى غير اللغة الإنجليزية، فإن خدمات المساعدة اللغوية متاحة لك في قسم الطوارئ لدينا.

### Deutsche (German)

ACHTUNG: Wenn Sie eine andere Sprache als Englisch sprechen, stehen Ihnen in unserer Notaufnahme Sprachunterstützungsdienste zur Verfügung.

### Tagalog (Tagalog)

Pansin: Kung nagsasalita ka ng isang wika maliban sa Ingles, ang mga serbisyong pantulong sa wika ay magagamit sa iyo sa aming Kagawaran ng Pang-emergency.

### русский (Russian)

ВНИМАНИЕ: Если вы говорите не на английском языке, вам доступны услуги языковой помощи в нашем отделении неотложной помощи.