**

Minidoka Medical Center │ RHC

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

**Patient Demographics**

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

 First MI Last

Date of Birth \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Select your primary medical provider in this office**

**\_\_\_Aaron Catmull, NP**

**\_\_\_Cameron McHan, NP**

**\_\_\_Shawna McCaffrey, NP**

**\_\_\_Brian Muir, DO**

**\_\_\_Alex Doroshkin, DM**

**\_\_\_Jeff Swenson, MD**

**\_\_\_Casie Taylor, NP**

**\_\_\_Mark Dahle, MD**

**\_\_\_Tyson Steel, DO**

**\_\_\_Brad Wynn, DO**

**\_\_\_Rebecca Warnick, NP**

\_\_\_**Tanya Crystal, NP**

Primary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth-date of Insured \_\_\_\_\_\_

Relationship to pt. \_\_\_\_\_\_\_\_\_\_SSN of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of deductible $\_\_\_\_\_\_\_\_\_\_ or Co-Pay $\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth-date of Insured \_\_\_\_\_\_\_\_\_

Relationship to pt. \_\_\_\_\_\_\_\_\_\_SSN of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* 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.

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

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

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Relationship to Patient**

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\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 **Name Relationship Phone**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_**\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_**\_**

*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.

\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial Here

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

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

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

**Signature of Patient/Patient Representative**

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

**Relationship to Patient**