

# PATIENT INFORMATION

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LAST NAME FIRST MI PHONE

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STREET / MAILING ADDRESS CITY/STATE/ZIP

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DATE OF BIRTH AGE SEX MARITAL STATUS SOCIAL SECURITY NO. REGULAR PHYSICIAN

MEDICATION ALLERGIES OR SPECIFIC MEDICAL CONDITIONS WE SHOULD BE AWARE OF

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EMPLOYER PHONE OCCUPATION

**RESPONSIBLE PARTY:**

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LAST NAME FIRST MI SOCIAL SECURITY NO. DATE OF BIRTH

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STREET ADDRESS CITY/STATE/ZIP HOME PHONE

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EMPLOYER PHONE OCCUPATION

DO YOU HAVE HEALTH INSURANCE? \_\_\_\_\_ YES \_\_\_\_\_ NO. PLEASE PROVIDE US WITH YOUR INSURANCE CARD SO THAT WE MAY COPY IT FOR OUR RECORDS.

PREFERRED LANGUAGE: \_\_\_\_\_

- RACE:**
- AMERICAN INDIAN OR ALASKA NATIVE
  - ASIAN
  - BLACK OR AFRICAN AMERICAN
  - NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
  - WHITE

- ETHNICITY:**
- HISPANIC OR LATINO
  - NOT HISPANIC OR LATINO

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EMERGENCY CONTACT PHONE RELATIONSHIP

**We ask for payment at the time of service unless other plans are pre-arranged.  
We are required to collect your insurance plan's co-payment at the time of service.**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to Physicians Immediate Care. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

## GENERAL INFORMATION ON PAYMENT AND PROCEDURE

1. If after sixty (60) days insurance has not responded to the claim, the billing is expected to be paid in full by the responsible party. We do require a payment within 30 days of time of service.
2. Patients with health insurance should remember that services are rendered and charged to the patient. Any dispute over an insurance claim is a matter between the patient and insurance carrier. Should a dispute arise, we will make every effort to help resolve the claim.

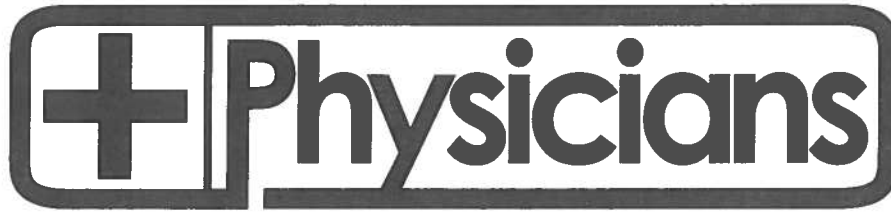
## AUTHORIZATION AND AGREEMENTS FOR TREATMENT

1. CONSENT TO TREATMENT: I understand that medical treatment will be performed by independent physicians, their assistants, and employees of Physicians Immediate Care Center between the hours of 8:00 a.m. and 7:00 p.m. Physicians Immediate Care Center is not responsible for care between the hours of 7:00 p.m. and 8:00 a.m. I hereby give my authorization and consent to treatment and procedures, and certify that no guarantee or assurance has been made as to the results of such treatment or procedures.
2. RELEASE OF MEDICAL INFORMATION: I hereby authorize **Physicians Immediate Care Center** to release any medical information in connection with these services for health insurance purposes or to the patient's treating physician or physicians.

I HAVE READ AND UNDERSTAND THE ABOVE ACKNOWLEDGMENTS AND AGREEMENTS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_





**Immediate Care Center**  
**260 Falls Ave. • Twin Falls, Idaho**  
**208.736.7422**

**ACKNOWLEDGMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES**

In signing this form, you agree that you have received our **Notice of Privacy Practices**. this Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment and health care operations.

You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that HSL and all affiliated covered entities can use and disclose your protected health information an accordance with HIPAA.

**Signature of individual or surrogate decision maker**

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**FULL NAME**

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**SIGNATURE**

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**DATE**



Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Special Considerations

- Legally blind
- Hearing impaired
- Pregnant
- Attempting Pregnancy
- Need handicap facilities
- None of the above

### Patient History

Please Make an (x) by any of these conditions you may have or had in the past:

- Heart disease
- High blood pressure
- High cholesterol
- Lung disease
- Diabetes (type 1 or 2)
- Hypoglycemia
- Thyroid disease
- Stomach disease
- Kidney, bladder or prostate disease
- Joint replacement
- Liver disease
- Bowel Disease
- Cancer (past or present)
- Anemia or other blood disease
- Blood Clots
- Bleeding tendency
- Stroke
- Seizures
- Nerve impairment
- Cervical spine disorder
- Lumbar spine disorder
- Severe headaches
- Tuberculosis/TB
- Muscle disease
- Mental health problems
- Depression
- Chronic skin Disease
- Sleep apnea
- Other

Past medical conditions

Current medications (Include non-prescription products ) include strength and dosage

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_ 7. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_ 8. \_\_\_\_\_

### Social History

- Do you smoke, chew tobacco or E-Vape?.....  Yes  No If yes, which one  S  C  E, \_\_\_\_\_ per day, \_\_\_\_\_ years of use.  
If no, any prior nicotine use? \_\_\_\_\_ years of use.
- Do you drink alcoholic beverages?.....  Yes  No If yes, \_\_\_\_\_ drinks per  day  week  month  Abuse
- Do or have you used any illegal substances?.....  Yes  No If yes, describe: \_\_\_\_\_
- Do you drink caffeinated beverages (coffee, tea, soda)..  Yes  No If yes, daily intake? \_\_\_\_\_

### Family History ( Any Cancer, Blood pressure, Cholesterol, Diabetes, etc... )

- Mother: \_\_\_\_\_  Deceased if yes, from what \_\_\_\_\_
- Father: \_\_\_\_\_  Deceased If yes, from what \_\_\_\_\_
- Other: \_\_\_\_\_

### Orthopedic or other major surgeries

Approx. date	Surgery	/	Approx. date	Surgery
Approx. date	Surgery	/	Approx. date	Surgery

**PEDS:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Special Considerations**

- Legally blind
- Need handicap facilities
- Hearing impaired
- Pregnant
- Attempting Pregnancy
- None of the above

**Pediatric Patient History**

School/ Daycare:	Level: _____ School/ Daycare name: _____ <input type="checkbox"/> involved in extracurricular activities
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Living Circumstances:	Patient Lives with: _____ Number of siblings: _____ Sleeping arrangements: _____ Number of pets: _____
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Potential Exposure to Toxins:	<input type="checkbox"/> Second Hand Smoke <input type="checkbox"/> Paint Fumes <input type="checkbox"/> Fertilizer <input type="checkbox"/> Misc. Chemicals <input type="checkbox"/> Lead
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**Past medical conditions**

\_\_\_\_\_

Current medications (Include non-prescription products) include strength and dosage

- 1. \_\_\_\_\_
- 3. \_\_\_\_\_
- 5. \_\_\_\_\_
- 7. \_\_\_\_\_
- 2. \_\_\_\_\_
- 4. \_\_\_\_\_
- 6. \_\_\_\_\_
- 8. \_\_\_\_\_

**Social History**

- Tobacco, E-vape use
- Alcohol use
- Drug use
- Caffeine use

**Family History (Diabetes, Cancer, high blood pressure ...)**

- Mother \_\_\_\_\_
- Father \_\_\_\_\_
- Other \_\_\_\_\_

**Orthopedic or other major surgeries**

Approx. date    Surgery	Approx. date    Surgery
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Approx. date    Surgery	Approx. date    Surgery
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