



Thank you for choosing Boise Surgical Group! We want your experience with our team of knowledgeable and skilled physicians to be as comfortable and worry-free as possible. We look forward to getting to know you!

### What to Bring:

- The following paperwork completely filled out
- Your insurance cards
- The amount of your insurance co-pay; or \$150 if you have no insurance.

#### *Special note for patients with insurance:*

- *Prior to scheduling surgery, we will collect 100% of the amount we estimate that will be left unpaid by your insurance*

#### *Special note for patients with no insurance:*

- *We will collect \$150 as a partial payment towards your office visit charge*
- *We will collect 50% (\$250-\$1000) of your estimated surgery charges prior to scheduling surgery*

Portico East Building off Eagle Road near  
St. Luke's Meridian Medical Center

Please see the enclosed map.

Please call us if there is any way we can help to make your visit better!

3399 E Louise Dr. #400, Meridian, Idaho 83642 (208)364-3000 main phone, (208)364-3191 fax



**Boise Surgical Group**  
 Leading the way in experience,  
 capabilities & surgical excellence.

*Please print*

Patient's First Name	Initial	Last Name	Marital Status	Date of Birth
Home Address			City	State
Home Phone	Cell Phone	Work Phone	Social Security #	
Employer	Occupation	Email Address (required)		
Spouse's First Name	Last Name	Date of Birth	Spouse's Cell Phone	
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone		
Insurance Policy Holder Name		Relationship to Patient	Social Security #	
Policy Holder Birth Date	Address (if different)		Phone numbers (cell, home)	
Emergency Contact		Phone Number	Relationship to Patient	

### MEDICAL HISTORY

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

**Sex** \_\_\_\_\_

Requesting Physician: \_\_\_\_\_

Cardiologist (if applicable) \_\_\_\_\_

Present Illness or condition: \_\_\_\_\_

Primary Care Provider \_\_\_\_\_

How long has this been present? \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

What are your symptoms (pain, etc)

\_\_\_\_\_

\_\_\_\_\_

Other medical problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous surgeries and approximate year performed \_\_\_\_\_

\_\_\_\_\_

Current Medications (if providing separate list, skip this section) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Do you have an allergy to (please mark with X): shellfish \_\_\_\_\_ iodine \_\_\_\_\_ x-ray dye \_\_\_\_\_ latex \_\_\_\_\_

### FAMILY MEDICAL HISTORY

	AGE	Major Diseases	Age at death	Cause of death
Father				
Mother				
Sibling				
Sibling				
Sibling				
Children:				

**Alcohol use** (please mark with X):

- Have never used alcohol
- Have used alcohol but quit
- Drink alcohol  
Drinks per day \_\_\_\_\_ per week \_\_\_\_\_

**Marital Status:**

- Single
- Married
- Divorced
- Widowed

**Tobacco use** (please mark with X):

- Have never used tobacco
- Cigarettes: Previous packs/day \_\_\_\_\_  
Current packs/day \_\_\_\_\_  
If you quit smoking, when did you stop? \_\_\_\_\_
- Cigars     Pipe     Smokeless

**Occupation:** \_\_\_\_\_

If retired, previous occupation \_\_\_\_\_

**Review of Systems:**  
Please indicate any personal history below:

**Constitutional Symptoms**

Good general health lately..... No Yes  
 Recent weight change..... No Yes  
 Fever..... No Yes  
 Fatigue.....No Yes  
 Headaches..... No Yes

**Eyes/Ears/Nose/Throat**

Blurred or double vision..... No Yes  
 Hearing loss or ringing..... No Yes  
 Chronic sinus problems..... No Yes  
 Nose bleeds..... No Yes  
 Sore throat or voice change... No Yes  
 Swollen glands in neck..... No Yes

**Cardiovascular**

Heart attack..... No Yes  
 Angina.....No Yes  
 High blood pressure..... No Yes  
 Swelling of feet or ankles..... No Yes  
 Leg pain, limited walking..... No Yes  
 Foot ulcers..... No Yes

**Gastrointestinal**

Trouble swallowing..... No Yes  
 Loss of appetite..... No Yes  
 Heartburn..... No Yes  
 Abdominal pain..... No Yes  
 Nausea or vomiting..... No Yes  
 Painful bowel movements..... No Yes  
 Frequent diarrhea..... No Yes  
 Constipation..... No Yes  
 Rectal bleeding/stool blood.... No Yes

**Skin and Breast**

Breast lump..... No Yes  
 Breast pain..... No Yes  
 Swollen lymph node..... No Yes  
 Nipple discharge..... No Yes  
 Rash or itching..... No Yes  
 Change in skin color..... No Yes

**Pulmonary**

Asthma/Wheezing..... No Yes  
 Pneumonia..... No Yes  
 Cough..... No Yes  
 Chest pain..... No Yes  
 Shortness of breath..... No Yes

**Endocrine**

Diabetes..... No Yes  
 Thyroid disease..... No Yes  
 Steroid or cortisone use..... No Yes  
 Hormone replacement..... No Yes

**Neurological**

Dizzy or light headed..... No Yes  
 Convulsions or seizures..... No Yes  
 Numbness or tingling..... No Yes  
 Where? \_\_\_\_\_  
 Stroke or tremors..... No Yes  
 Head injury..... No Yes

**Genitourinary**

Frequent urination..... No Yes  
 Burning/painful urination... No Yes  
 Male-testicle pain..... No Yes  
 Female-painful periods..... No Yes  
 Female-vaginal bleeding... No Yes  
 Female-# if pregnancies \_\_\_\_\_  
 Female-#of miscarriages \_\_\_\_\_  
 Could you be pregnant?... No Yes

**Renal**

Kidney stone..... No Yes  
 Kidney failure/dialysis..... No Yes  
 Urine incontinence..... No Yes

**Hematology/Oncology**

Anemia..... No Yes  
 Blood clot..... No Yes  
 Cancer: Type \_\_\_\_\_  
 Coumadin treatment..... No Yes  
 Leukemia..... No Yes  
 Aneurysm..... No Yes

**Psychiatric**

Depression..... No Yes  
 Panic attacks/anxiety..... No Yes  
 Insomnia..... No Yes

*Sign Here:* \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date reviewed: \_\_\_\_\_

# Credit Policy

Payment for co-pays, co-insurance, and unmet deductibles are expected at the time service is rendered. Any amount that is not either paid or discounted under the terms of your insurance contract will be owed by you. If you do not have insurance, 50% of the estimated charges are due prior to surgery, with the balance owing within 45 days of the statement date. For your convenience, we accept VISA, MasterCard, and Discover. We also accept personal checks drawn on an Idaho bank. A \$25.00 service charge will be assessed on all returned checks.

We will bill your insurance company for you as a courtesy; however, if your insurance company denies coverage for any of the services we render, the amount due will be your responsibility to pay. We will attempt to get the pre-authorizations that your insurance company requires; however, this is ultimately your responsibility and we advise you to contact your insurance company personally to obtain any preauthorization they require. If the proper authorization is not obtained, the amount due will be your responsibility to pay. If an overpayment occurs, the overpay amount received by us will be refunded to the party that overpaid.

## DELINQUENT ACCOUNTS:

Accounts that are not paid in accordance with the above terms will be referred to a collection agency. We do offer payment plans in the case of a hardship. Please consider making these arrangements prior to your account going delinquent. Unfortunately, if your account is referred to a collection agency, it cannot be retrieved and your credit rating may be damaged. Please contact our billing office at 208-472-9112 to make arrangements.

### What if I do not have insurance?

*If you are:*

- 1) *Not covered under an insurance plan*
- 2) *Waiting or applying for financial assistance*
- 3) *Waiting for a Worker's Compensation case approval*

*Please be prepared to pay \$150 deposit towards your initial consultation. This deposit will not pay for the full cost of the visit, additional charges will follow. Prior to surgery, we will also collect 50% of the estimated surgery charges and arrange a payment plan for the unpaid balance.*

### What if I have an unmet deductible?

*Prior to surgery, we will collect the full amount of the estimated charges that we expect to be unpaid by your insurance.*

*I understand and agree to the terms of the Boise Surgical Group credit policy above. I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, metals and any other diseases or condition, including pregnancy. I agree to update any changes in the medical history while under the care of Boise Surgical Group. This authorization is valid until revoked by me in writing.*

\_\_\_\_\_  
*Sign Here*

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

\_\_\_\_\_  
*Print Name*

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

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

*Sign Here:* \_\_\_\_\_

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

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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## 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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") requires that all identifiable health information is kept properly confidential. Under this Act, the patient has new rights to understand and control how his or her health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

### *What information we collect*

We (physicians and staff) collect information from your previous medical providers, from you, and from tests and procedures that are performed while you are under our care. This may include your health status, health care & services you receive at this office, psychiatric history, family and social history, and medical history and HIV/AIDS status. This information is kept isolated within your paper and electronic chart, and access is limited to our employees who need the information to perform their duties.

### *What information we disclose*

We may use and disclose your medical records for these purposes: treatment, payment and healthcare operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending a patient for a radiology test.
- Payment means billing, preauthorization, verifying insurance coverage, utilization review, and collection activities. An example is sending a bill to your insurance company for our services.
- Health care operations include the business aspect of running our practice. This includes conducting quality assessment and improvement, auditing, cost-management, and customer service analysis. An example would be an internal quality assessment audit.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual. We may also use de-identified health information by removing all individually identifiable information. We may disclose your health information to family members or other individuals that are involved in your care.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. Examples of disclosures requiring your written authorization include records sent to an attorney or records sent to an entity for purposes of deciding disability status.

### *Special Situations*

**To Avert a Serious Threat to Health or Safety** We may release health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required by Law** We will disclose health information about you when required to do so by federal, state, or local law.

**Military, National Security & Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

**Workers' Compensation** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks** We may disclose health information about for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Law Enforcement** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

### *Your Rights Regarding Health Information About You*

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members or any person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you remove it in writing.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

As a covered entity, Boise Surgical Group is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices. Our group is required to abide by the terms of this Notice of Privacy Practices as it is currently in effect.

We reserve the right to change the terms of the Notice of Privacy Practices and make the new provisions effective for all protected health information we maintain. If we do revise our Notice of Privacy Practices, a revised copy will be posted in our office, posted on our website, will be provided to all new patients upon their first visit, and will be available upon request.

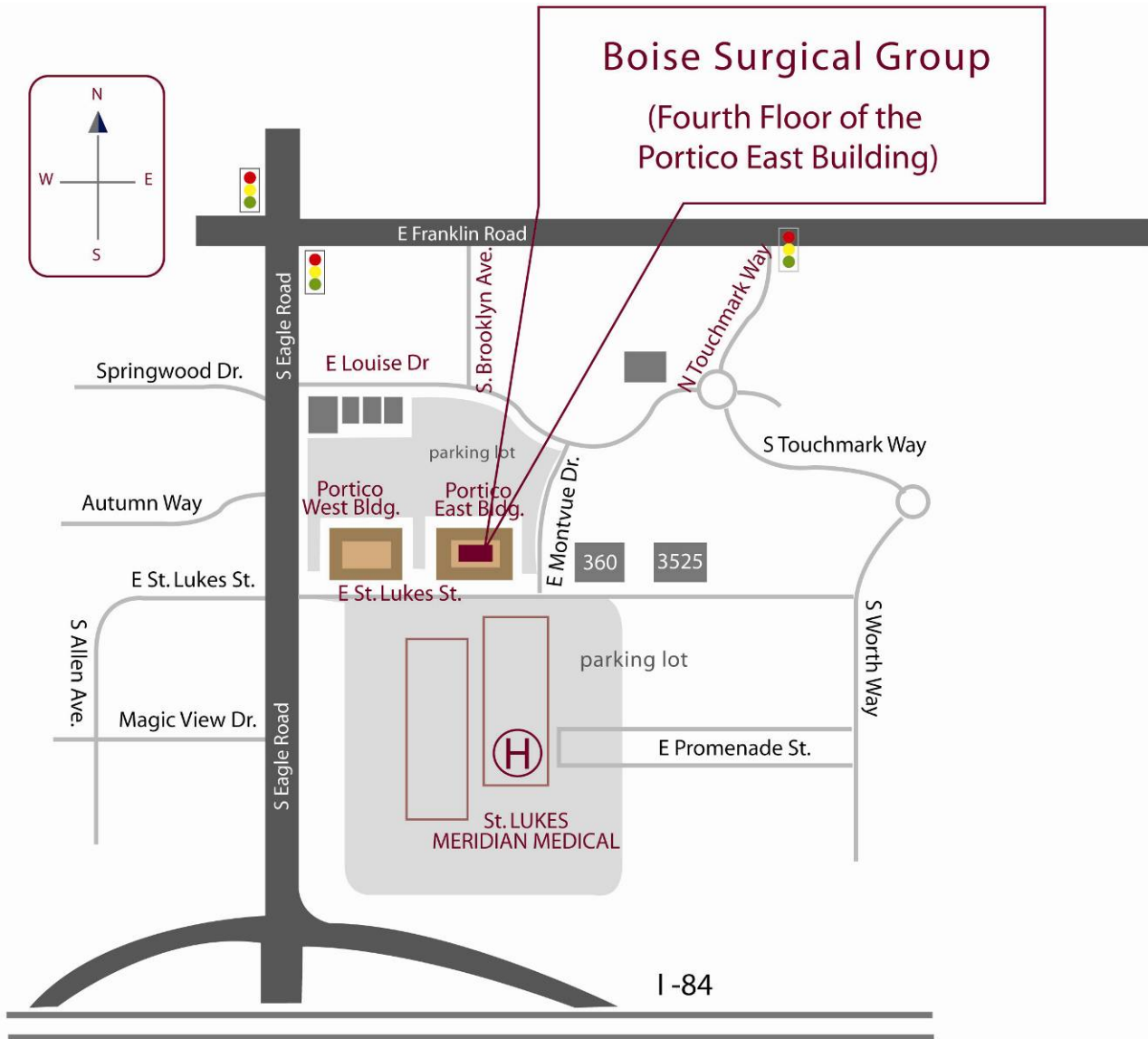
If you need further clarification of anything contained in this Notice of Privacy Practices, please contact our Office Manager at 364-3000.

This notice is effective as of April 1, 2003.

If you feel your privacy rights have been violated, you may file a written complaint with our Privacy Officer or with the Secretary of Health & Human Services. Any individual who files a complaint will not be retaliated against.

Boise Surgical Group  
Attn: Privacy Officer  
3399 E Louise Dr. #400  
Meridian, ID 83642  
(208) 364-3000

Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, SW  
Washington, DC 20201  
(202) 619-0287  
Toll Free 1-877-696-6775



Portico East