



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 an unmet deductible over \$500:

- *We will collect 30% (\$250-\$750) of your estimated surgery charges prior to scheduling surgery*

Special note for patients with no insurance:

- *We will collect \$150 as a partial payment towards your office visit charge*
- *We will collect 30% (\$250-\$750) of your estimated surgery charges prior to scheduling surgery*

Parking:

Please review the enclosed map, and do not hesitate to use the free valet parking that is provided for your convenience. This service is included in the cost of your treatment. The valet symbol on the enclosed map will guide you to the nearest valet station.

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

Appointment with Dr. _____

Referring Dr. _____

Patient Information (Please Print)

Reason Referred _____

Patient's First Name	Initial	Last Name	Gender	Marital Status	Date of Birth
Home Address	City		State	Zip	Email address (required)
Home Phone	Cell Phone		Work Phone/Ext.	Social Security #	
Employer	Occupation	Address	City/State		Zip
Spouse's First Name	Last Name		Date of Birth	Spouse's Cell Phone	
Spouse's Employer	Spouse's Occupation		Spouse's Work Phone	Employer's Address	

Responsible Party Information (if different than above)

Resp. Party Name (Guarantor, if minor)		Relationship to Patient	Social Security #
Emergency contact		Relationship to Patient	Phone Number
Home Phone	Work Phone	Employer	Occupation

Insurance Information

Primary Insurance Company	Policy Holder	Date of Birth	SS#	Relationship to Patient
Policy #	Group #	Group Name/Employer		
Secondary Insurance Company	Policy Holder	Date of Birth	SS#	Relationship to Patient
Policy #	Group #	Group Name/Employer		

Please Read and Sign Below

I hereby assign to BSG all funds to which I am entitled for medical and/or surgical expenses related to the services performed, but not to exceed my indebtedness to BSG. Any overpayments will be refunded to me or the appropriate payer. BSG is authorized to make photocopies of this agreement; and I release BSG from all legal responsibility or liability which may arise from this authorization. I also certify this information is true and correct to the best of my knowledge. I will notify BSG of any changes in my status or the above information.

Sign here: _____ *Date:* _____

Credit Policy

Payment for co-pays are expected at the time service is rendered. Additionally, if you have no insurance, or an unmet deductible over \$500, we require 30% of your estimated surgery charges to be prior to performing surgery. For your convenience, we accept American Express, 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. 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. If your insurance company does not pay what you expected, the deficient amount is your responsibility and due within 45 days of the statement date. If an overpayment occurs, the overpay amount received by us will be refunded to you.

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 208-367-2834 to make arrangements.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered. I understand and agree to the terms of the Boise Surgical Group credit policy above.

Sign Here

Date

Patient Name

MEDICAL HISTORY

Requesting Physician: _____ Cardiologist (if applicable) _____

Present Illness or condition: _____ Primary Care Provider _____

How long has this been present? _____

What are your symptoms (pain, etc.)? _____

Other medical problems: _____

Previous surgeries (please list dates) _____

Major hospitalizations or serious injuries (please list dates): _____

Current Medications (please list with dosage): _____

Medication Allergies (and specific reaction, if known): _____

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

FAMILY MEDICAL HISTORY

	AGE	Diseases	Age at death	Cause of death
Father				
Mother				
Siblings:				
Grandparent				
Grandparent				
Spouse				
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

Occupation: _____

If retired, previous occupation: _____

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

Recreational drug use:

- Currently using?
 Previously used?
 Type of drugs used: _____

Sign Here: _____

Review of Symptoms:
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:** _____

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 _____

Relationship to Patient _____

Sign Here: _____

Date _____

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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Important Facts to Know

1. Will my surgery require an assistant surgeon?

In most cases, your surgery will not require an assistant surgeon. On occasion, a procedure may require an assistant surgeon, or other assistant, as deemed necessary. We often employ the help of non-physician surgical assistants. Usually, the fees for assistants are billed through our office.

2. Does my insurance require pre-authorization for procedures?

We 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. We will bill your insurance company for you as a courtesy.

3. What if I do not have insurance?

If you are:

- 1) not covered under an insurance plan*
- 2) on, 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 30% of the estimated surgery charges and arrange a payment plan for the unpaid balance.

4. What if I have an unmet deductible over \$500?

Prior to surgery, we will also collect 30% of the estimated surgery charges.

5. Whom do I contact with questions about my bill?

Please call our billing office at 208-367-2834, extension 115.

I have read and understood the above.

Sign Here

Date

Print Name

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.

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 367-2834.

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
6140 W. Curtisian Ave. #102
Boise, Idaho 83704
(208) 367-2834

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

