THE IDAHO CENTER FOR INTEGRATIVE MEDICINE

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www.theICIM.com

New Patient Information – Chiropractic/Acupuncture

Personal:
Last Name: _____ First Name: _____ Middle Initial: ____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____ Cell: (____) _____ Email: _____

Birth date: _____ Sex: M / F Marital Status: M / S Social Security #: _____

Ethnicity/Race: _____ Date of Injury:_____

Emergency Contact: _____ Phone: (_____) _____

Work:
Occupation: _____ Employer: _____ Office #: _____

Primary Insurance Information:
Health Plan: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Member ID Number: _____ Group Number: _____

Secondary Insurance Information:
Health Plan: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Member ID Number: _____ Group Number: _____

___ **I understand there is a $35 fee** for any **missed appointment** or failure to provide **notice 24+ hours in advance**
___ **It is my responsibility to pay** any deductible, co-insurance, and/or any other balances not covered by insurance or other third party payers. My signature indicates that I agree to pay for any outstanding bills incurred in this office.
___ **I authorize that payment be made directly to my provider** at the Idaho Center for Integrative Medicine for any and all insurance benefits or reimbursement for services rendered. **I also authorize the release of any information concerning my health and healthcare services** to my insurance companies, Medicare, or other pre-paid healthcare plans.

_____ _____
Patient Signature (Parent if Minor) Date

HEALTH INFORMATION FORM

Patient name: _____ Date: _____

Whom may we thank for referring you to our office? _____

Do you have a medical doctor? ____Yes ____No If yes, Doctor's name: _____

Doctor's phone number: _____ Approx date of last visit: _____

Family History:

Please indicate if anyone in your immediate family has a history of the following:

Arthritis ____No ____Yes Relationship_____ Disease _____

Heart Disease/Stroke ____No ____Yes Relationship_____ Disease_____

Cancer ____No ____Yes Type_____ Relationship_____

Diabetes ____No ____Yes Type_____ Relationship_____

Genetic Disorders ____No ____Yes Type_____ Relationship_____

Personal Past History

Please indicate if you have had any of the following:

Surgeries ____Yes ____No Describe _____

Hospitalizations ____Yes ____No Describe _____

Major Injuries ____Yes ____No Describe _____

Major Illnesses ____Yes ____No Describe _____

General Health Questions:

Blood Pressure_____ Weight:_____(in pounds) Height:_____(in inches)

List all Medications: _____ _____

List all Allergies (food, medication):_____

Do you currently smoke tobacco of any kind? ____Yes _____Never a smoker ____ Former smoker

If yes, how often do you smoke per day? ___ 1-3 ___ 4-10 ____ 10-20 ____ 20+

If yes, what is your level of interest in quitting smoking: 0 1 2 3 4 5 6 7 8 9 10

Has any doctor diagnosed you with Hypertension presently? ____ Yes _____No

Has any doctor diagnosed you with Diabetes presently? _____Yes _____No

If yes, was your blood work test for hemoglobin A1c > 9.0% ____Yes ____No

Reason for Visit:

What is your primary complaint? _____

How severe is your pain? 0=no pain, 10=unbearable pain 0 1 2 3 4 5 6 7 8 9 10

What treatment have you had for these complaints?_____

Have you had x-rays, MRI's or other tests for this condition? ____Y ____N Date:_____

Location_____ Results:_____

Patient Name:_____ **Date**: _____

In order for us to better serve you, and to make better recommendations for therapies and treatments best suited to your individual needs, please carefully review the items below.

PLEASE CIRCLE ANY THAT APPLY , and note whether it is NOW or in the PAST.

General Health ❑ No Problems - Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other:_____

Ears, Nose, & Throat ❑ No Problems - hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness, Other:_____

Cardiovascular ❑ No Problems - Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking, Heart Attack (MI), Stroke, Other: _____

Respiratory ❑ No Problems - Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray, COPD, Asthma, Pulmonary Embolism Other: _____

GI (Stomach & Intestines) ❑ No Problems - Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence, hemorrhoids, Other: _____

GU (Kidney & Bladder) ❑ No Problems - Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Pain with sex, UTI, STD's, Erectile Dysfunction, Other: _____

Musculoskeletal ❑ No Problems - Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain, numbness, tingling, weakness, tears, fracture, bursitis, Other: _____

Dermatological ❑ No Problems - Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes, Other: _____

Neurologic (Brain & Nerves) ❑ No Problems - Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems -Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrine (Glands) ❑ No Problems - Intolerance to heat or cold, menstrual irregularities, frequent hunger /urination thirst, changes in sex drive, breast augmentation, Other: _____

Hematologic (Blood/Lymph) ❑ No Problems - Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems - Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV, Cancer. Other: _____

Patient Name: _____ Date: _____

Consent to Treat and Authorization to Release Information

The undersigned consents to examination which may include physical, orthopedic, neurological, laboratory, and radiographic as needed to evaluate and or diagnose the patient.

The undersigned also consents to therapeutic procedures as are deemed necessary by their doctor in the course of treatment. These therapeutic procedures may include any of the following: Spinal and extra spinal manipulation/adjustments, ice, heat, electrical muscle stimulation, ultrasound, soft tissue manipulation, taping, exercise, nutritional supplementation, minor surgery, intravenous therapy, stitching, and any other procedures as prescribed by the doctor.

The doctors and staff make every effort within their power to minimize risks involved in any procedure. In spite of that, there may be a very small risk of complications.

I have read the above information and by my signature give my consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline any procedure I am not completely comfortable with.

I hereby provide authorization for the provider and staff to complete insurance claims as I may request, and understand that records will be held in confidence and not released for any other purpose.

____ **(initials)** I have been given the **Notice of Privacy Practices form** (see attached), and I agree to its contents.
____ **(initials)** I have been given the **HIPAA Email Consent** form (see attached), and I choose:

☐ OPTION #1 - **I agree to** receive personal health information ***via email***, even if it may be unencrypted.

OR

☐ OPTION #2 - I do **NOT** want personal medical information sent via email. (Please note that by sending an email with health-related questions to staff or practitioners at the ICIM implies you give consent to receive such correspondence).

_____ _____

Patient Date

_____

Signature **(parent or guardian if patient is a minor)**

ICIM FINANCIAL POLICY

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is essential that if your insurance carrier sends you forms that need to be signed for authorization for records that you sign these documents and send the completed forms back to the carrier as soon as possible. T**here is no guarantee that your insurance company or pre-paid healthcare plan will cover or pay for any charges, and you are responsible for all remaining charges.**

General:
All accounts are due and payable upon receipt of a mailed patient statement unless other arrangements are made at the time of service. Deductibles and co-pays are due at the time of service. Accounts over 30 days of the first mailed statement will accrue a finance charge of 1.5% per month or 18% per year. Any and all accounts owing over 90 days may be turned over to a collection agency and may accrue a finance charge at the rate of 2% per month or 24% per year. A $35.00 returned check charge will be added to all returned checks.

The Idaho Center for Integrative Medicine (ICIM) has one set fee schedule; however, the amount that patients are responsible for will vary depending on their benefit coverage. If patients do not have private health insurance, Medicaid, Medicare, or other covered benefit plan, they are entitled to a "Time of Service" discount. Under this discount plan, payments are expected the same day the service was performed, and in exchange for prompt payments, the ICIM will offer 10-20% discounts depending on applicable laws (the government restricts the amount that can be discounted legally). The exact discount can be determined at the front office. Under certain circumstances, financial hardship plans are accepted by the ICIM, and if you feel as though your financial circumstances are such that you may require discounts beyond the customary Time of Service discounts, please inquire options at the front office. A Financial Hardship Form must be signed in these cases.

Health Insurance:
Your insurance is a contract between you and the insurance company. For your convenience, we will be happy to submit your charges to your insurance company. Not all services are a covered benefit in all contracts. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Work Comp:
If you are involved in a work-related injury, your employer and/or worker's comp insurance policy is responsible for the cost of care. You will not receive a bill once the insurance carrier/employer has accepted the claim. You are responsible for creating the claim with your employer, and the claim number will be needed in order to receive treatment in our office.

Auto Injury:
If you are injured in a motor vehicle accident, we will submit claims to your auto insurance, even if you are not at fault. If you have Med Pay on your auto insurance, your treatment is covered until the Med pay runs out or treatment is finished. Your Med Pay carrier is responsible to pay over the course of care, while the insurance of the liable party will only pay at the time of settlement. When your Med Pay is exhausted, we may submit claims to your health insurance, or make other arrangements with you. You may be asked to sign an Assignment Agreement so we can submit bills to your auto insurance and/or attorney and receive payments directly from them. Even if you are not at fault in an accident, there is no guarantee that treatment rendered in this office will be covered, and **you are responsible for all charges incurred.**

Medicare, Medicaid:
We accept patients with Medicare and/ or Medicaid coverage. These programs provide limited coverage and do not pay for commonly used procedures in this clinic including myofascial release, exercises, PT modalities, and examinations. Medicare patients are responsible for deductibles, co-pays and all of these non-covered services. Medicare patients are required to fill out an Advanced Beneficiary Notice (ABN) form that will show the costs of the common non-covered services. Medicaid patients are responsible for non-covered services, but are not responsible for deductibles or co-pays.

My signature indicates I have read and understand this financial policy.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following:

   Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

   Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain payment for treatment.

   Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

   Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by your consent, office policies, or other applicable laws and regulations, including the following:

   - To avoid a serious threat to your health or safety or the health or safety of others.
   - As required by state or federal law such as reporting abuse, neglect or certain other events.
   - As allowed by workers compensation laws for use in workers compensation proceedings.
   - For certain public health activities such as reporting certain diseases.
   - For certain public health oversight activities such as audits, investigations, or licensure actions.
   - In response to a court order, warrant or subpoena in judicial or administrative proceedings.
   - For certain specialized government functions such as the military or correctional institutions.
   - For research purposes if certain conditions are satisfied.
   - In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
   - To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. **Disclosure We May Make Unless You Object.** Unless you instruct us otherwise, we may disclose your information as described below.

   - To a member of your family, relative, friend or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3. **Uses and Disclosures With Your Written Authorization.** Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosure of psychotherapy notes; for most marketing purposes. You may revoke your authorization by submitting a written notice to the

Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restriction on the use or disclosure of information for treatment, payment or healthcare operations. We are *not* required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone, mail at your home address and possibly by e-mail if you have given your e-mail address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Privacy Officer:	Dr. Noah Edvalson
Phone:	208-629-5374
Address:	3224 N. Maple Grove Rd
	Boise, ID 83704
Email:	theicim@gmail.com

8. Effective Date. This Notice is effective January 12, 2014.

HIPAA email consent

HIPAA stands for the *Health Insurance Portability and Accountability Act*

HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information Information stored on our computers is encrypted

Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email

When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.

In addition, once the email is received by you, someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR- 2013- 01- 25/pdf/2013- 01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.
You have **TWO OPTIONS**

OPTION # 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to the Idaho Center for Integrative Medicine to send me personal health information via unencrypted email.

OPTION #2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

****Please initial your preferences on your New Patient Intake Forms****