BOISE ENT

PATIENT REGISTRATION: PATIENTS 18 YEARS AND OLDER

Date: _____ Social Security Number _____

Patient

Last Name _____ First Name _____ Initial _____

Date of Birth _____ Gender: ◯ Female ◯ Male Email _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ Phone (Cell) _____

Phone (Work) _____ Preferred Contact Phone: ◯ Home ◯ Cell ◯ Work

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other(Multi-racial) ☐ Unknown ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other _____

Preferred Language ◯ English ◯ Spanish ◯ Other _____

Employer _____

Employer Address _____ City _____ State _____ Zip _____

Who is your current / past primary care provider? _____

Preferred Pharmacy _____ Major Crossroads _____

Health Insurance

(Clinic: If unable to scan card, make copy and attach. If card is unavailable, write info on this form.)

Primary Insurance _____ ***(Employer ONLY needed if different from above.)***

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Secondary Insurance _____

Policy Holder Name _____ Date of Birth _____

Employer _____ Relationship to Patient _____

Employer Address _____ City _____ State _____ Zip _____

Additional Contact

(Not living with you)

Last Name _____ First Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

Advanced Directives

(Living Will)

Would you like more information about Advance Directives? ◯ Yes ◯ No

Brochure Provided? ◯ Yes ◯ No

People assisting with paperwork:

_____ Interpreter's name	_____/_____ Interpreter's Signature / and/or ID #	_____ Date and Time
_____ Office Staff name	_____ Office Staff Signature	_____ Date and Time

Place patient sticker here or handwrite
Name: _____
DOB: _____

HIPAA – PHI Release Form: *Patients 18 years and Older* SAHS-1320

Name: _____ Date of Birth _____

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally

☐ You have my permission to speak with my Spouse/Significant Other about my medical care and test results.
Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to speak with my children or other family members involved with my medical care.
Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

Name _____ Phone _____
Relationship _____

☐ You have my permission to leave information on my answering machine regarding my medical care and test results.

☐ You have my permission to email me information regarding my appointments, medical care and test results.

☐ Other, please describe: _____

Emergency Contact:
Last Name _____ First Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____
Relationship to Patient _____

Patient Contact
Patient Email _____
Phone (Home) _____ Phone (Cell) _____
Phone (Work) _____ Preferred Message/Contact Phone ☐Home ☐Cell ☐Work

Patient Signature _____ Date _____ Time _____

People assisting with paperwork:

_____	_____/_____	_____
Interpreter's name	Interpreter's Signature / and/or ID #	Date and Time
_____	_____	_____
Office Staff name	Office Staff Signature	Date and Time

HAVE PATIENT/GUARDIAN DATE AND INITIAL

Reviewed____/____/_____ Date / Time / Initials	Reviewed____/____/_____ Date / Time / Initials
Reviewed____/____/_____ Date / Time / Initials	Reviewed____/____/_____ Date / Time / Initials
Reviewed____/____/_____ Date / Time / Initials	Reviewed____/____/_____ Date / Time / Initials

IMPORTANT INFORMATION

Boise ENT honors the sacredness and dignity of every person, complies with applicable Federal civil rights laws, and does not discriminate on the basis of protected classes, including but not limited to, race, color, national origin, age, disability, or sex.

Boise ENT:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats such as large print, audio, accessible electronic and other formats
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Community Services Coordinator at 1-208-229-2368.

If you believe that Boise ENT has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance in person, by mail, or fax to:

- Patient Relations Coordinator,
- Boise ENT, LLC
  8854 W Emerald St
  Suite 150
  Boise, ID 83704
- Office: 208-229-2368
  Fax: 1-888-815-1651

If you need help filing a grievance the Patients Relations Coordinator is available to help you.

You can also file a civil rights complaint with the US Department of Health & Human Services, Office of Civil Rights electronically via web, by mail or phone to:

- US Department of Health & Human Services, 200 Independence Avenue, SW Room 409F,
- HHH Building, Washington, DC 20201
- Web: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1-800-368-1019 | TTY 1-800-537-7697

Arabic
إذا كنت بحاجة إلى هذه الخدمات ، فاتصل بمنسق خدمات المجتمع على 1-208-229-2368

Basque
Zerbitzu horiek behar badituzu, jarri harremanetan gure Komunitateko Zerbitzuen Koordinatzailearekin 1-208-229-2368 telefonoan

Chinese
如果您需要这些服务，请致电 1-208-229-2368 联系我们的社区服务协调员

French
Si vous avez besoin de ces services, contactez notre coordonnatrice des services communautaires au 1-208-229-2368

Japanese
これらのサービスが必要な場合は、コミュニティ サービス コーディネーター (1-208-229-2368) にご連絡ください。

Korean
이러한 서비스가 필요하면 커뮤니티 서비스 코디네이터에게 1-208-229-2368로 문의하십시오.

Nepali
यदि तपाईंलाई यी सेवाहरूको आवश्यक छ भने, हाम्रो सामुदायिक सेवा समन्वयकलाई 1208-229-2368 मा सम्पर्क गर्नुहोस्

Russian
Если вам нужны эти услуги, свяжитесь с нашим координатором общественных услуг по телефону 1-208-229-2368.

Serbian
Ако су вам потребне ове услуге, контактирајте нашег координатора за услуге заједнице на 1-208-229-2368

Spanish
Si necesita estos servicios, comuníquese con nuestro Coordinador de servicios comunitarios al 1-208-229-2368

Swahili
Ikiwa unahitaji huduma hizi, wasiliana na Mratibu wetu wa Huduma za Jamii kwa 1-208-229-2368

Urdu
اگر آپ کو ان خدمات کی ضرورت ہے ، تو ہمارے کمیونٹی سروسز کوآرڈینیٹر سے 1-208-229-2368 پر رابطہ کریں

Vietnamese
Nếu bạn cần những dịch vụ này, hãy liên hệ với Điều phối viên Dịch vụ Cộng đồng của chúng tôi theo số 1-208-229-2368

PLEASE REVIEW WITH YOUR NURSE/MA

Tobacco (Annual)

Do you use tobacco products regularly, occasionally, or recreationally? ◯No ◯Yes

Are you exposed to second hand smoke? ◯ No ◯ Yes

Functional Status (Annual / as needed)

Have you noticed any change in your ability to take care of yourself or do any of your usual activities? ◯ No ◯ Yes

At any time do you feel concerned for the safety/well-being of yourself and/or your children, in your home or elsewhere?
◯ No ◯ Yes

Nutrition (Annual / as needed)

Have your eating habits changed for any reason since your last visit? ◯No ◯Yes

Any change in appetite, ability to eat, or any foods or weight changes that you affected you differently. ◯No ◯Yes

Alcohol Consumption

◯ No ◯ Yes ◯ Formerly Type _____ Frequency _____ Amount _____

Street Drug Use: ◯ No ◯ Yes Type _____

Depression Screening (As needed)

Over the last 2 weeks, how often has your child been bothered by any of the following problems?

Little interest or pleasure in doing things: ◯ Not at all ◯ Several days
◯ More than half of the days ◯ Nearly every day

Feeling down, depressed, or hopeless: ◯ Not at all ◯ Several days
◯ More than half of the days ◯ Nearly every day

Fall Risk (Annual / as needed)

Have you fallen in the last year? ◯No ◯ Yes If yes, how many times? _____

Do you have problems with walking or balance? ◯No ◯ Yes

Do you have any barriers to learning? (Annual)

Are there any needs (learning, ethnic, cultural, or spiritual) we should know about that might impact your care or your ability to understand treatments / procedures / educational materials? ◯ No ◯ Yes

How do you best learn? (Annual)

◯ audio materials ◯ demonstrations ◯ written materials ◯ verbal explanations ◯ video materials

Social History (Annual)

Living arrangements: ◯ Alone ◯ Family/Significant Other ◯ Other ◯ Assisted Living

◯ Daily help needed for self-care Name of caregiver _____

Chaperone Needed: ◯ No ◯ Yes

Health Maintenance (Annual)

Date of last colonoscopy: _____ Where: _____

Date of last Eye Exam: _____ Where: _____

Date of last Dental Exam: _____ Date of last flu/pneumococcal vaccination: _____

Date of last EKG: _____

MALE Only (Annual) Last PSA: _____

Women Only (Annual)

Date of last pap: _____ Last menstrual period? _____

Date of last Mammogram: _____ Where: _____

List all medications here: _____

_____

BOISE ENT™

List all medications here (cont.)

History

Are you currently pregnant? ◯ No ◯ Yes

Family History (mark all that apply and indicate for Mother, Father, Siblings):			
☐ ADD/ADHD ☐ Alcoholism ☐ Allergies ☐ Alzheimer's disease ☐ Arthritis ☐ Asthma ☐ Blood disorder ☐ Cancer ☐ Cardiovascular disease ☐ Coronary artery disease	☐ Coronary artery disease, premature ☐ Depression ☐ Developmental delay ☐ Diabetes ☐ Eczema ☐ Elevated lipids ☐ Genetic disease ☐ Hearing deficiency ☐ Hypertension ☐ Irritable bowel syndrome	☐ Learning disability ☐ Mental Illness ☐ Migraines ☐ Obesity ☐ Osteoporosis ☐ Peripheral vascular ☐ disease ☐ Renal disease ☐ Seizure disorder ☐ Stroke ☐ Thyroid disorder ☐ Other_____	Age/Cause of death of: Mother: n/a _____ Father: n/a _____ Siblings: n/a _____ Siblings: n/a _____ Siblings: n/a _____ Siblings: n/a _____

Past Medical History: Please mark all that apply.			
☐ Allergies ☐ Anemia Angina ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation ☐ Blood Clots	☐ Cancer type: ☐ Cardiac arrhythmia ☐ COPD ☐ Coronary artery disease ☐ Depression ☐ Diabetes ☐ Elevated lipids ☐ Gallbladder disease	☐ GERD ☐ Headache-migraines ☐ Heart disease ☐ Heart valve disorder ☐ Hepatitis/Liver disease ☐ Hypertension ☐ Irritable bowel syndrome ☐ Myocardial infarction	☐ Osteoporosis ☐ Renal disease ☐ Seizure disorder ☐ Stroke ☐ Thyroid disease ☐ Other:_____ _____ _____

Past Surgical History	List Year	Past Surgical History	List Year
☐ Angioplasty		☐ LASIK	
☐ Appendectomy		☐ ORIF (Open reduction, internal fixation related to broken bones)	
☐ Arthroscopy		☐ Thyroidectomy	
☐ Back surgery		☐ Tonsillectomy	
☐ Blood transfusion		☐ Other	
☐ CABG (Coronary Artery Bypass Graft)		Please list any other health issues that you have experienced that were note listed above: _____ _____ _____	
☐ Cardiac pacemaker			
☐ Carpal tunnel release			
☐ Cataract extraction			

CONSENT TO MEDICAL CARE AND PATIENT SERVICES AGREEMENT SAHS – 604

Patient Name: _____ ("Patient") Date of Birth: _____

Provider: _____

1. Consent to medical care. I consent to and authorize the physicians, nurses, and other health care providers at Boise ENT, and their respective affiliated entities (individually, as applicable, and collectively, "Boise ENT" and such providers, "Providers"), acting within the scope of their licenses, to perform such tests (including, without limitation, blood draws, lab tests and x-rays), examinations, procedures and treatments as: (i) Patient's Providers deem necessary or advisable to determine Patient's health and/or to diagnose and treat Patient's disease, injury, pain, discomfort and/or dysfunction; and(ii) are routinely preformed with respect to an initial or follow-up visit to an outpatient clinic or an admission to an acute care hospital, including, without, limitation, responding to emergency medical conditions (collectively, "Routine Procedures"). With respect to Routine Procedures, and except in cases of emergency that prevent immediate discussion, I understand that Patient's Providers will discuss with me Patient's condition, the proposed treatment, alternative treatments and non-treatment, and the likelihood of success, risks, benefits, and side effects of the proposed treatment, alternative treatments and non-treatment (collectively, "Procedure Information"). I will immediately let Patient's Providers know if I have unanswered questions regarding the Procedure information, I no longer consent to the test, examination, procedure or treatment in question. I further understand that prior to any test, consent to the test, examination, procedure or treatment in question. I further understand that prior to any test, examination, procedure or treatment being performed on Patient that goes beyond a Routine Procedure (a "Non-Routine Procedure"), I will be presented with an additional consent form to execute and that I will have the right and opportunity to withhold my consent to such non-routine Procedure. Although I expect the care given Patient will meet customary standards, I understand that there are no guarantees concerning the result of Patient's care. I assume full risk and responsibility and release Boise ENT and Providers from responsibility for things that may go wrong if Patient does not receive the medical care and treatment recommended to me.

2. Assignment of Payments from Insurance for Services. I hereby assign to Boise ENT the right to receive directly all payments otherwise payable to me or my benefit in connection with all medical treatment, services, and/or hospitalization rendered to me by Boise ENT. I authorize all payors to make all payments directly to Boise ENT. This is only a limited assignment of any right to payment I may have. By making such assignment, I in no way obligate or require Boise ENT to perform any contractual obligations I may have in connection with such payment. This assignment is the only assignment I am making to Boise ENT and, in the event of a conflict from any other document, is the controlling assignment between Boise ENT and me, including, but not necessarily limited to, any assignment of benefits carried on my insurance benefits card. Notwithstanding this assignment of payment and any other plan or benefits card provision to the contrary, I specifically acknowledge and agree that I am personally liable for the medical treatment, services and/or hospitalization provided by Boise ENT, its employees, agents, independent contractors, or physicians as detailed below. If a Third Party Payor, including but not limited to, an insurer or ERISA plan, does not fully reimburse Boise ENT for the care I receive, I specifically acknowledge and independently agree that I am liable for any balance owing, including any costs and attorney fees incurred in collection of such amount.

3. Financial Policy. If Patient has an emergency medical condition, any review or discussion of financial policies will be delayed until after the medical screening examination, and a medical screening examination will be provided regardless of my ability to pay. I agree to abide by the financial policies relating to my payment obligations for medical care received by Patient as such policies are adopted from time to time by Boise ENT and acknowledge that a copy of such policies is available in the registration area and upon request. I further understand and agree that I am financially responsible for payment of all charges incurred which are not paid by any Third-Party Payors, including, without limitation, any and all products provided or services rendered to patient which are not eligible for payment by any Third-Party Payors (e.g., services rendered by health care providers who do not participate with patient's insurance plan). Noncovered services may also include those services Patient's Providers determine to be medically necessary, but are determined unnecessary by the applicable Third-Party Payors.

Place patient sticker here or handwrite
Name: _____
DOB: _____

4. Providers. I understand that many Providers in the hospital, including Patient's attending physician, may not be employees or agents of Boise ENT, but instead are independent contractors or physicians who have been granted the privilege of attending to patients at a Boise ENT hospital ("Independent Providers"), that these Independent Providers may not necessarily participate with the same Third Party Payors as Boise ENT, and that these Independent Providers are entitled to send their own bills for services they provide Patient in addition to any bills I receive from Boise ENT.

5. Trainees. I understand that certain individuals at Boise ENT facilities are in training to become Providers and that such individuals may observe, and within the bounds of applicable law and Boise ENT policy, may assist in Patient's care as part of their education, and I consent to such observation and assistance

6. Filming and Observers. I consent to Boise ENT taking photographs, recording video, and preparing drawings and other graphic materials of Patient and any of Patient's treatments and procedures for scientific, educational, and training purposes; provided, Patient's identity is not revealed by such media or by any descriptive text accompanying them. I further consent to Boise ENT taking photographs, recording video, and preparing drawings and other graphic materials of Patient for diagnostic, treatment, and identifying purposes. In addition, i consent to the presence (whether actual or through closed-circuit television) of observers during Patient's treatments and/or procedures at Boise ENT, including representatives of medical equipment and device manufacturers; provided, such observers' presence is solely for scientific, educational or training purposes.

7. Safety Remote Video Monitoring. I acknowledge that Boise ENT may use a remote video monitoring device to observe me when needed to ensure my safety while hospitalized. The remote video monitoring device does not record audio or video.

8. Telemedicine. I understand that techniques of telemedicine may be employed to facilitate Patient's medical care, including, without limitation, video imaging of patients and electronic transmission of radiographic images (e.g., X-rays), laboratory results, and vital signs. All electronic transmission of data will be performed in compliance with applicable law and Boise ENT' privacy practices.

9. Tissue Disposal. I consent to Boise ENT disposing of any tissue, body parts, hardware or fluids that are removed from Patient during any procedure or treatment at Boise ENT.

10. Blood-Borne Pathogens Testing. I consent to Boise ENT testing Patient's blood for HIV and other blood-borne pathogens in the event: (i) a Boise ENT employee, Provider, or emergency responder is exposed to patient's bodily fluids and such exposure could result in transmission of a bloodborne disease; or (ii) any of Patient's Providers determines such testing is medically advisable.

11.Personal Valuables. Any personal property brought with Patient and not needed for purposes of Patient's stay at the Boise ENT facility must be taken home. Boise ENT will not be liable for loss of, or damage to, any personal property of Patient, except during periods such personal property has been placed in a Boise ENT safe depository.

12. Communications. Subject to any limitations set forth by separate document regarding disclosure of Patient's PHI, I agree that with respect to patient's appointments, medical care, and payment for such care, Boise ENT and its assignees and designees, including, third-party collection agents (collectively, "Boise ENT Parties"), are authorized to communicate with me, through either a live person or an automated dialing system with artificial or pre-recorded voice and through a variety of media, including, through telephone calls (both to my landline and wireless phone numbers), mail, emails, and text messaging, even when I may incur third-party service charges for such communications. I also hereby consent to each of the Boise ENT Parties: (i) leaving answering machine and voicemail messages for me (including, messages regarding amounts owed by me and other information required by law, including debt collection laws); and (ii) using the same media to communicate with me with respect to other matters, such as marketing and fundraising. I understand, however, that my consent to the immediately preceding clause (ii) is not required to receive services from Boise ENT.

Place patient sticker here or handwrite
Name: _____
DOB: _____

13. Use and Disclosure of Health Care Information. I understand that Boise ENT may collaborate with or be contacted by other health care providers to coordinate, manage and provide health care to Patient, and I consent to Boise ENT sharing Patient's health information and records electronically or otherwise for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to Patient and other patients (e.g., avoiding unnecessary or duplicate testing, etc.).

I consent to the inclusion in Patient's electronic health records ("EHR") of sensitive diagnoses and related information such as HIV/AIDS, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The EHR will be accessible by Boise ENT credentialed Providers as well as other individuals approved to access the EHR or obtain EHR information via data exchanges with the EHR for purposes related to treatment, payment, health care operations and/or other purposes permitted by the Health Insurance Portability and Accountability Act (as amended, supplemented or otherwise modified from time to time, "HIPAA"). As required by HIPAA, Boise ENT has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of Patient's information while under the control of Boise ENT.

I agree that Boise ENT may use and disclose Patient's health information for a range of purposes, such as: treatment, eligibility verification, and/or payment to healthcare providers, regulators, Third-Party Payors or their agents, including insurance companies, managed care organizations, state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance and qualifications of Providers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements, and public health and health oversight services.

I consent to Boise ENT' request for Patient's health information from Third Party Payors and other providers of care to Patient, receipt of and release of Patient's health information to or from Third Party Payors, providers of care and social service agencies, whether written, verbal, or electronic, for the uses described above. I also consent to Boise ENT' participation in health information exchanges and other data exchanges for treatment, payment and operations, including the sharing of Patient's information electronically.

I acknowledge that a copy of the current Boise ENT Notice of Privacy Practices (the "Privacy Notice") was offered to me and is available in the registration area and upon request. I understand that the Privacy Notice provides additional information about how Boise ENT may use and disclose protected health information ("PHI") and that I have certain rights to request to restrict use of Patient's PHI. _____ (initials)

14. Patient Rights and Responsibilities. I acknowledge that the Patient Rights and Responsibilities brochure was offered to me and is available in the registration area and upon request. I understand the brochure includes information about visitation rights, Advance Directives, as well as information regarding other patient rights and responsibilities_____ (initials)

15. Hospital Directory. Unless I object below, Boise ENT will use and disclose certain information about me in the hospital directory while I am in the hospital so that my family and friends may visit me and know how I am doing. The information in the hospital directory includes my name, location in the hospital, and general condition (e.g., fair, stable, critical, etc.).

☐ I agree to the use and disclosure of the above information in the hospital directory.

☐ I do not want the above information included in the hospital directory or disclosed to people who ask for me by name. By choosing this option, I opt out of Boise ENT' hospital directory and understand deliveries (e.g., flowers, cards) and other items sent to me will be returned and will not be delivered.

Place patient sticker here or handwrite
Name: _____
DOB: _____

CONSENT TO MEDICAL CARE AND PATIENT SERVICES AGREEMENT SAHS – 604

16. Duration of Consent. For outpatient clinic visits, this written consent shall remain valid for one year from the date of Patient's/Patient Representative's signature, unless revoked in writing prior to that time. For hospital visits, a new written consent shall be obtained for each visit, unless the visits are for continuing and repetitive procedures (e.g., chemotherapy, pain management, radiation oncology, dialysis, and rehabilitation therapy).

This form has been explained to me, and I certify that I have read it, understand its contents, and have had an opportunity to have my questions answered. By signing this form, I consent to medical care by Providers and to each of the provisions set forth in this form. In the event I do not understand, or consent to, any provision of this form, I will immediately speak with a representative of Boise ENT to ask questions or to register my lack of consent. I acknowledge, however, that in certain cases such lack of consent may prevent Providers from providing Patient with medical services, may shift all or a portion of the financial obligation for such services to me, and/or may be of no effect to the extent Boise ENT has already taken action in reliance upon any consent given hereby.

Signature of Patient	Date	Time
Staff Signature (Witness)	Date	Time

The patient is unable to sign because _____

For this reason, I give consent to medical care on behalf of the above-named patient.

Signature of Patient's Representative	Relationship to Patient	Date	Time
Staff Signature (Witness)		Date	Time

_____ Language Line utilized, or _____ Hospital interpreter

Interpreter's name	Interpreter's Signature / and/or ID #	Date	Time
Staff Signature (Witness)		Date	Time

- For office use only - Phone consent

Person Accompanying Patient	DOB	Relationship to Patient	Phone
Legal Guardian	DOB	Relationship to Patient	
Mailing Address		Phone	Email Address
Staff Signature (1st Witness)		Date	Time
Staff Signature (2nd Witness)		Date	Time

Place patient sticker here or handwrite
Name: _____
DOB: _____