Dear Patient,

Welcome! Marimn Health is recognized as a Patient Centered Medical Home. A Medical Home provides services that are patient-centered. The Medical Home acts as the primary point of care for the patient and the relationship between the patient and his/her family. We are happy to serve you as a new patient. To make your visit with us more pleasant, please complete the registration information. We do require that you bring in the necessary items listed below so we are able to register you in our practice.

All patients must present the following:

- Picture ID
- Current medical/dental insurance eligibility cards, including Medicaid and Medicare

In order to establish eligibility for Indian Health Services, Native American applicants must also present the following:

- Tribal Enrollment Card or Certificate of Indian Blood
- If a descendant, a letter of descendancy from your affiliated tribe or a birth certificate and a copy of parents' tribal information

To establish eligibility for our Sliding Fee Program, please bring a copy of your most recent tax return and documentation of your place of residence.

Patients are responsible to pay in full for services received unless Marimn Health is provided appropriate documentation establishing Indian Health Service and/or the Sliding Fee Program. We expect payment at time of service of any co-pays, deductibles, and co-insurance.

**It is important that you provide your signature at the bottom of the first page, the acknowledgement of receipt, and the self-determination sections.**

Thank you for your cooperation,

Marimn Health
First Impressions Department

MARIMNHEALTH
COEUR D'ALENE TRIBE

Please select the location(s) you are requesting below:

☐Medical ☐Dental ☐Behavioral Health ☐Optical ☐Chiropractic

## Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____

Date of Birth: ____/____/____ **Gender (at birth):** ☐Male ☐ Female ☐ Choose Not to Disclose

Social Security # (SSN): _____ Email Address: _____

Home Phone #: _____ Cell Phone #: _____

Notification Preference: Phone Email Text Patient Portal

Emergency Contact: _____ Relationship: _____ Phone Number: _____

**Mailing Address:**

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

**Physical address** (*if different from mailing address)*:

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

**Employer:** _____

**Guarantor Information** (*Complete **ONLY** if patient is a minor)*:

Parent/Guardian Name: _____ Relationship: _____ Date of Birth: _____

Phone #:

## Insurance Information:

Primary Insurance: _____ Policy ID #: _____ Group#: _____

Name of Policy Holder: _____ DOB: / / Policy Holder SSN #: _____

Secondary Insurance: _____ Policy ID #: _____ Group#: _____

Name of Policy Holder: _____ DOB: / / Policy Holder SSN #: _____

*IF YOU HAVE INSURANCE COVERAGE, IT MUST BE BILLED BEFORE INDIAN HEALTH FUNDS ARE APPLIED. AS A COURTESY, WE WILL BILL YOUR INSURANCE FOR SERVICES RENDERED AT MARIMN HEALTH. THE PATIENT OR LEGAL GUARDIAN IS RESPONSIBLE FOR PAYMENT OF ALL SERVICES NOT COVERED BY INDIAN HEALTH OR BY YOUR INSURANCE.

*I AUTHORIZE MARIMN HEALTH TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO THE PHYSICAN AND CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. STATEMENTS MAY BE SENT AS A COURTESY BUT PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE. PAYMENT IN FULL MAY BE DEMANDED AT ANY TIME.

*I REQUEST AND CONSENT TO TREATMENT AT MARIMN HEALTH, INCLUDING MEDICAL, DENTAL, COUNSELING, SUBSTANCE ABUSE, PHARMACY, AND ANY OTHER SERVICE OFFERED AT THE CLINIC OR WELLNESS CENTER. THIS FACILITY PROVIDES COMPREHENSIVE AND INTEGRATED HEALTH AND WELLNESS SERVICES AND USES A SHARED MEDICAL RECORD. FURTHERMORE, I AUTHORIZE MY PROVIDER AND ANY OTHER PROVIDER WHO MAY ATTEND TO ME, THEIR ASSISTANTS, NURSES, AND ANY OTHER IN-HOUSE STAFF TO PROVIDE THE SERVICES DEEMED NECESSARY BY MY PROVIDER.

*IN CONSENTING TO TREATMENT, I UNDERSTAND THAT RESULTS OF MEDICAL TREATMENT VARY AND I HAVE NOT BEEN GUARANTEED SPECIFIC RESULT

SIGNATURE: _____ Date: _____

Front Desk Staff Only: MR #: _____ Staff Initials: _____

*The following information helps Marimn Health with funding from several grant sources which better enables us to provide quality care within our communities. We would greatly appreciate it if you would take the time to complete the information requested.*

**Homeless Status:** □ Doubling Up □ Not Homeless □ Shelter □ Street □ Transitional □ Unknown/Unreported
**Migrant Worker Status:** □ Migrant □ Not a Farmworker □ Not a Migrant Worker □ Seasonal
**Language Barrier:** □ Yes □ No
**Race**: □ American Indian □Caucasian □Asian □African American □ Other_____
**Veteran:** □ Yes □ No
**I Consider Myself Primarily:** □Hispanic □Non-Hispanic □Other □Decline to Specify
**Are you a member or descendant of a Federally Recognized Tribe?** □ Yes □ No Tribe Name: _____
****To establish eligibility for Indian Health Services, Native American applicants **must** also present the following:*

- *Tribal Enrollment Card or Certificate of Indian Blood*
- *If a descendant; a letter of descendancy from your affiliated tribe or a birth certificate and a copy of parents' tribal information*

**Gender Identity:**

□Female □Male □ Female-to-Male □Male-to-Female □Choose Not to Disclose □Other: _____

**Sexual Orientation**:

□ Straight □ Gay □ Bisexual □Choose Not to Disclose □ Other_____

**Pronouns (ex. she, them, he, they, etc.): _____**

**Please circle the answer that best describes you and your family.**

**Family Size:** 1 2 3 4 5 6 7 8 Other: _____

**Family Income**:

Under $13,000 $13,000-$20,000 $20,000-$30,000

$30,000-$40,000 $40,000-$50,000 $50,000-$60,000

$60,000-$70,000 $70,000-$80,000 Over $80,000

The patient Self-Determination Act is a law passed in 1990. It states that clinics that get Medicare or Medicaid funding are required to offer patients information on the Advanced Directive, such as a living will or durable power of attorney, and we are required to ask if a patient already has an Advanced Directive in place.

**□ I do □ I don't currently have an Advanced Directive in place.**

*If you would like more information on Advanced Directive, please ask your provider for an information packet.*

SIGNATURE: _____Date: _____

**Front Desk Staff Only:** **MR #:** _____**Staff Initials:** _____

# 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 THIS NOTICE CAREFULLY.*

We may use and disclose your personal health information:

- For treatment activities, both at Marimn Health and to referring doctors
- To bill for your services
- To conduct our day-to-day business and service operations
- Marimn Health participates in the Idaho Health Data Exchange where other health care providers involved in your care may access your health information.
- To give appointment reminders via phone and mail
- To provide interpretation services, if needed
- To inform you of helpful health-related services and treatment alternatives provided that we do not receive payment for these communications.
- To keep friends, family members or personal representatives who are involved in your care or payment for your care informed, as long as you have agreed to this disclosure.
- To funding agencies as required by law and who support your care such as Indian Health Service, Bureau of Primary Health Care, Purchased and Referred Care, Veterans Administration, etc.
- To avert a serious threat to health or safety
- For worker's compensation claims
- For public health protection interventions as required by law
- As required for lawsuits and legal disputes
- To law enforcement as required by law
- To coroners, health examiners and funeral directors
- To national security, intelligence agencies, and protective services as required by law.
- To certain specialized government functions, e.g. military, prisons, etc.
- Other uses and disclosures not included in our *Notice of Privacy Practices* will be made only with your written authorization.

Your Rights:

- You have a right to be informed of our privacy practices, and to request a copy of the complete *Notice of Privacy Practices* handout.
- To inspect and copy your personal health information. You have the right to request an electronic or paper copy of your health information records.
- To request amendment of your health information records
- To receive an accounting of disclosures of your health information
- To request restrictions on the uses or disclosures of your health information
- To receive confidential communications by alternative means or at alternative locations
- To receive notification if there is an unauthorized disclosure of your protected health information.
- To choose someone to act for you
- To choose to opt out of having your health information shared with the Idaho Health Data Exchange
- To file a complaint without threat of retaliation if you believe your privacy rights have been violated. For assistance, please contact the Privacy Officer at (208)686-5071.

**PATIENT ACKNOWLEDGEMENT OF RECEIPT:**

I, _____, hereby acknowledge that I have read and understand this Notice of Privacy Practices.

**Date of Birth:** _____

**SIGNATURE**: _____Date: _____

**Front Desk Staff Only:** **MR #:** _____**Staff Initials:** _____

# HIPAA Compliance Patient Consent Form

Patient Name: _____

Date of Birth: _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Marmin Health reserves the right to change the privacy policy as allowed by law.
- Marimn Health has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Marimn Health may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? _____YES _____NO
May we leave a message on your answering machine at home or on your cell phone? _____YES_____NO
May we discuss your medical condition with any member of your family? _____YES _____NO
*If YES, please name the members allowed:*

1._____

2._____

3._____

Information to be disclosed:

☐ Medical Records
☐ Labs/X-rays
☐ Other: _____

_____

Consent Signed by:(printed): _____

Signature: _____ Date: _____

**Front Desk Staff Only:** **MR #:** _____ **Staff Initials:** _____

# Authorization for Release of Medical Records

MARIMN HEALTH
COEUR D'ALENE TRIBE

**Patient Information:**

Patient Full Name: _____ D.O.B. _____ Phone#_____

| Information to be released from | Information to be sent/released to: |
|---|---|
| Name of Facility: | Name of Facility: |
| Address: | Address: |
| City/State/Zip: | City/State/Zip: |
| Phone/Fax Numbers: | Phone/Fax Numbers: |

*IF RECORDS ARE MORE THAN 50 PAGES, DO NOT FAX. PLEASE MAIL TO: PO BOX 388, PLUMMER, ID 83851

**Information to be released: (PLEASE SELECT ONE):**

☐ The most recent 2 years of pertinent information (Chart notes, labs, x-rays, and special tests)
(Records from Marimn Health will only be released. We will not release any records from an outside facility.)

☐ Immunizations

☐ Specific Information (Please specify): _____

**Purpose for which disclosure is being made**: (Please check one of the following)

☐ Attorney ☐ Insurance ☐ Doctor ☐ Personal

**Patient Authorization:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drugs and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
***EXCLUDE** the following information from the records released (Please initial):

_____Drug/Alcohol Abuse/Treatment and Diagnosis _____ Sexually Transmitted Disease

_____HIV/AIDS Diagnosis/Treatment/Testing _____ Mental Illness or Psychiatric Diagnosis/Treatment

**My Rights:**

I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. (To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released). I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. No charge for medical records released directly to provider/ facility for continued care. There may be a copying fee for medical records released directly to the patient.

For personal requests of records, I prefer to have copies of my records given to me: ☐ electronically OR ☐ paper

**Signature**:_____**Print Name**: _____**Date**: _____
If Minor, Select one: ☐ Parent or ☐ Guardian

**Marimn Health Representative:** _____**Date:** _____ **MRN:** _____

**In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington DC, 20250-9410 or call (702) 720-5964 (voice and TDD).**
**This authorization will expire 90 days from the date signed unless otherwise specified.**

Patient Name: _____
DOB: _____

MARIMNHEALTH
COEUR D'ALENE TRIBE

# Comprehensive Patient History Form

Name: _____ MRN_____ Date: _____

**Main Reason For Visit:**

_____
_____

**Other Concerns:**

_____
_____
_____

**Please list healthcare providers & their specialty you see regularly:**

_____
_____
_____

**List any medical supplies you use (e.g. oxygen, wheelchair):**

_____
_____

**Medication List:** ☐ Check if you do not take any prescription or over the counter medications.

***Please note, medications will be reviewed at your Establish Care Visit prior to prescribing or refilling medications. ***

| Medication | Dose | Directions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Controlled Substances (i.e. Hydrocodone, Oxycodone, Xanax, Adderall, suboxone, etc) | Dose | Directions |
| | | |
| | | |
| | | |
| | | |

MARIMNHEALTH
COEUR D'ALENE TRIBE

Patient Name: _____
DOB: _____

**Allergies or reactions:**

| Allergy | Reaction (e.g. swelling, rash, stomach problem, breathing difficulty) |
|---|---|
| | |
| | |
| | |
| | |

Preferred Pharmacy: _____

**Preventative Care:**

Date of last Colon and Rectal Screening: _____ Result if known: Normal or Abnormal

Date of last eye exam: _____ Date of last dental exam: _____

**Past Medical History:** (*Check all that apply.)*

- ☐ Acid Reflux
- ☐ Alcohol/Drug Abuse
- ☐ Allergy Problems
- ☐ Anemia
- ☐ Anxiety
- ☐ Artery/Vein Problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Problems
- ☐ Blood Clots
- ☐ Cancer
- ☐ Cataracts
- ☐ Colitis/Crohn's
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Esophagitis
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Thyroid Issues
- ☐ Heart Disease
- ☐ Heart Valve Problem
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable bowel
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease/Hep
- ☐ Lung Disease
- ☐ Migraines
- ☐ Mental Health Diagnosis
- ☐ MRSA
- ☐ Osteoporosis
- ☐ Recurrent Skin Infection
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually Transmitted Infect.
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ TB

Other diseases not listed above: _____

Hospitalizations/Significant Injuries: _____

_____

MARIMNHEALTH
COEUR D'ALENE TRIBE

Patient Name: _____
DOB: _____

**Surgery/Procedures History:** *(Check all that apply)*

- ☐ Appendix
- ☐ Bladder Suspension
- ☐ Blood Vessel Surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Colon/Rectal Surgery
- ☐ Dental Surgery
- ☐ Eye Surgery
- ☐ Gallbladder
- ☐ Hernia
- ☐ Heart Surgery
  - ☐ Bypass
  - ☐ Heart Valve
  - ☐ Angioplasty
  - ☐ Stents
  - ☐ Pacemaker
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial
- ☐ Joint replacement/Orthopedic surgery
- ☐ Kidney Surgery
- ☐ Organ Transplant
- ☐ Prostate Surgery
- ☐ Thyroidectomy
- ☐ Sinus Surgery
- ☐ Tonsils and/or Adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

Other Surgery not listed above: _____

☐ Previous reaction to anesthesia (explain): _____
_____

**Family History:**

Adopted: ☐ Yes ☐ No Skip family history if yes and unknown.

| Family Member | Age(s) | Living | Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother(s) # | | | |
| Sister(s) # | | | |

**Diseases in the family:** *(check all that apply)*

- ☐ Arthritis
- ☐ Addiction Problems
- ☐ Bleeding Problems
- ☐ Cancer: Who?
  - ☐ Breast:_____
  - ☐ Colon:_____
  - ☐ Prostate:_____
  - ☐ Other:_____
- ☐ Depression/Anxiety
- ☐ Diabetes:_____
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Illness

**For our FEMALE patients only:**

Date of last menstrual period: _____
Do you have a Gynecologist ☐ Yes ☐ No If yes, Gynecologist name: _____
Date of last PAP test:_____ Date of last mammogram: _____
Have you gone through menopause ☐ Yes ☐ No
Menstrual problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____
Number of pregnancies: ____ Number of live births:___ Number of abortions: ____
Current birth control method: _____
Have you had a bone density (DEXA) exam? YES NO Date: _____