Monarch Healthcare
Delivering tomorrows promises, today.

Patient Information

Date	Preferred Pharmacy: Name & Location	
Name: Last	First	Middle (initial)
Date of Birth:	Sex Male Female	Social Security Number
Marital Status Single Married Divorced Widowed Other		Drivers License Number
Billing Address		
Zip	City	State

Phone: Home	Work	Cell	Preferred Contact Number Home Work Cell
Preferred Communication		Email Address	
Emergency Contact: Name, Address and Phone Number of nearest friend of relative *not* living with you.			Relationship

Patient Employer Name	Occupation	Contact Number
Spouse Employer Name	Occupation	Contact Number

Insurance Coverage – *Primary Plan*		Insurance Coverage – *Secondary Plan (if applicable)*	
Insured Name	Policy Holder Name, DOB, Relationship	Insured Name	Policy Holder Name, DOB, Relationship
Policy Number	Group Number	Policy Number	Group Number
Effective Date		Effective Date	

Release of PHI

As outlined in Monarch Healthcare's "Notice of Privacy Practices", we may disclose your protected health information (PHI) to individuals or entities involved in your healthcare. Provide the names of individuals you ***do not*** want to receive your PHI.

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Release for Treatment of a Minor

Except under certain legal exemptions, a parent or guardian signature is required for the treatment of a minor. I am the parent/guardian for

____
Name of Minor

and give Monarch Healthcare authorization to provide treatment.

____
Parent/Guardian Signature

____
Witness Date

Consent for Treatment

I consent to examination, diagnosis and medical care including office lab services (blood draws), injections and imaging (ultrasound, AFI) to be performed by providers and employees of Monarch Healthcare.

____
Patient or Guardian Signature

____
Date

Health Questionnaire

Name ______________________ Date of Birth __________ Age _____ Date _______

Family Practice Physician ______________________ Preferred Pharmacy ____________________

Problems to Discuss During Your Visit:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Do You Have any Allergies?: *List all allergies including medication, food, skin, environment, etc.*

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Current Medications: *List all medications including: Medication, Dosage, Prescriber and Reason for medication.*

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Surgery History:

Date	Type of Surgery	Date	Type of Surgery

Pregnancy History: *Include all miscarriages, abortions or tubal pregnancies.*

Date of Delivery	# Weeks at Delivery	Hours in Labor	Birth Weight	Sex	Delivery Type – Vaginal, CSection, Forceps	Complications

Medical History: *List current problems, past diagnoses and hospitalizations.*

1.	4.	7.
2.	5.	8.
3.	6.	9.

Examples: Diabetes, Depression, Stroke, Anemia, STDs, High Blood Pressure, Asthma, etc.

Do You Smoke? Yes No How many cigarettes a day? __________
Do You Drink? Yes No How much? __________________

Health Questionnaire

Reproductive History:

Age of 1st Menses ___________

Date of Last Pap Smear ___________

Date of Last Colonoscopy ___________

Date of Last Period ___________

Date of Last Mammogram ___________

Date of Last Bone Density Scan ___________

Have you ever had an abnormal pap smear? Y N

Sexual History:

Are you using any method to prevent pregnancy: Yes No

If Yes which type (please circle)? Pill Tubal Vasectomy Condoms Depo-Provera IUD Diaphragm Rhythm Other ___________

Do you have pain with intercourse? Yes No

Family Medical History:

	Yes	No	Relative (Maternal/Paternal		Yes	No	Relative (Maternal/Paternal)
Breast Cancer				Heart Disease			
Colon Cancer				High Blood Pressure			
Ovarian Cancer				Kidney Disease			
Endometrial Cancer				Blood Clotting Disorders			
Diabetes							
Other___________				Other___________			
Other___________				Other___________			

Patient Financial Agreement

We are dedicated to providing you with the best possible care and consider your understanding of this financial agreement an essential part of the services you receive at Monarch Healthcare.

SERVICES: Services received by a MH provider requiring payment may include: Office visits, office procedures, lab drawing fees, ultrasound tests, diagnostic tests, hospital visits and hospital surgeries.

- **Laboratory:** We use Express Labs for most routine lab work. Express Labs may send some work out to other labs. MH sends non-routine lab work to other labs. You will receive statements directly from the respective lab for these services.

BILLING PROCESS: As a courtesy, MH will file insurance claims on your behalf after you have received care. Upon receipt of insurance payment, you will receive an explanation of benefits (EOB) and/or a statement from MH with the remaining balance owed. Additionally, MH providers participate in Medicare and accept assignment under Medicare.

DISCOUNTS FOR INSURED PATIENTS: Idaho Statute 41-348(b)(2) prohibits healthcare service providers from regularly waiving, rebating, giving, paying, or offering to waive, rebate, give or pay all or a part of a claimant's deductible or claim for health insurance.

PAYMENTS: We will work with you and your insurance company to determine your specific responsibility associated with the discounted rate we've agreed to accept from insurance. However, ***it is ultimately your responsibility to understand your insurance policy and benefits. You are ultimately responsible for payment of the services you receive from MH – including services not covered under your insurance policy.***

For all services provided, payments may include your remaining deductible, your estimated copayment and/or your coinsurance depending on your insurance plan.

If you are private pay or do not have insurance, a business office representative will work with you to determine the applicable charges and your payment responsibilities.

We require all applicable copayments and/or coinsurance at the time of your visit.

For **Obstetrics** we require payments during your pregnancy.

For **Procedures/Surgeries:** We require a pre-payment of 50% of the estimated amount you owe prior to the procedure/surgery.

Full payment is due prior to the procedure/surgery for ***elective*** *procedures/surgeries not covered by insurance.* Failure to make your prepayment may result in postponing your procedure/surgery.

Failure to honor your commitment to a payment plan may result in your account being sent to collections.

INTEREST: Interest of 1.5% per month begins accruing after 45 days on any unpaid balances.

RETURNED CHECKS: A $25.00 fee will be charged for all returned checks not honored by your bank.

COLLECTIONS: Accounts turned over to an outside collection agency will incur an additional 30% fee. ***If your account is turned to a collection agency all future medical care provided at Monarch Healthcare will require payment in full at the time of service.***

I have reviewed this patient financial agreement; I understand the content of the agreement and agree to the terms.

Patient/Responsible Party Signature	Printed Name	Date