Patient Information

Monarch Healthcare
Delivering tomorrows promises, today.

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.

_____

_____

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

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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.*

_____
_____

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

_____
_____
_____
_____

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

Monarch Healthcare

Reproductive History:

Age of 1st Menses _____
Date of Last Period _____
Date of Last Pap Smear _____
Date of Last Mammogram _____
Date of Last Colonoscopy _____
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 either: payment based upon statements for services provided during your pregnancy or an agreed upon monthly payment based on your estimated financial responsibility for 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 $20.00 fee will be charged for all returned checks not honored by your bank.

COLLECTIONS: ***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. If my account is turned to a collection agency I agree to pay any collection costs and/or attorney's fees on any delinquent balances placed for collection or suit.***

Regarding automated messages we leave for you: To the extent consent is required by the Telephone Consumer Protection Act ("TCPA") or other applicable law, I hereby authorize Monarch Healthcare and its designees to deliver messages to the phone number(s) I've provided through the use of an automatic telephone dialing system or an artificial or prerecorded voice. I understand that I am not required to agree to receive such automated calls, and my agreement is not a condition to receiving items or services from Monarch. I understand that Monarch reserves the right to contact me by any means as otherwise permitted by law.

I have reviewed and understand and agree to the terms of this agreement.

Patient/Responsible Party Signature	Printed Name	Date