Patient Information

Date	**Preferred Pharmacy: Name & Location**		
Last Name	**First Name**	**Middle (initial)**	
Date of Birth	**Sex** Male Female	**Social Security Number**	
Marital Status Single Married Divorced Widowed Other		**Driver's License Number**	
Billing Address			
Zip	**City**	**State**	
Phone: Home	**Work**	**Cell**	**Preferred Contact Number** Home Work Cell
Who should we thank for referring you?	**Email Address**		
Emergency Contact: Name of nearest friend or relative	**Phone number**	**Relationship**	
Patient Employer Name	**Occupation**	**Contact Number**	
Spouse Name DOB & Employer Name	**Occupation**	**Contact Number**	
Insurance Coverage – *Primary Plan*	**Insurance Coverage – *Secondary Plan (if applicable)***		
Primary Insured Name Policy Holder Name, DOB, Relationship	**Secondary Insured Name** Policy Holder Name, DOB, Relationship		
Subscriber Number/Policy Number /ID # Group Number	**Subscriber #/Policy Number/ID#** Group Number		
Effective Date	**Effective Date**		

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

Monarch Healthcare
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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, C-section, Forceps	Complications

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

1.	3.	5.
2.	4.	6.

Examples: Diabetes, Depression, Stroke, Anemia, STDs, High Blood Pressure, Heart Disease, Kidney Disease, Blood Clotting Disorders, Asthma, etc.

Your Family's Medical History: *List current problems, past diagnoses and hospitalizations.*

1.	3.	5.
2.	4.	6.

Examples: Diabetes, Depression, Stroke, Anemia, STDs, High Blood Pressure, Heart Disease, Kidney Disease, Blood Clotting Disorders, Asthma, etc.

Do You Smoke? Yes No How many cigarettes a day? _____
Do You Drink? Yes No How much? _____ Married_____Single_____Widowed_____

Health Questionnaire

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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

Instructions: This is a screening tool for cancers that run in families. Please circle Y for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.
You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren.

You & Your Family's Cancer History: (please be as thorough and accurate as possible)

Y / N	CANCER	YOU AGE of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	Relatives on your MOTHER'S SIDE	Age of Diagnosis	Relatives on your FATHER's SIDE	Age of Diagnosis
Y / N	Breast Cancer (female or male)							
Y / N	Ovarian Cancer (Peritoneal/Fallopian Tube)							
Y / N	Uterine (endometrial) Cancer							
Y / N	Colon/Rectal Cancer							
Y / N	10 or more lifetime colorectal polyps (specify #)							
Y / N	Other cancer(s) (specify cancer type)							

Y / N	Are you of Ashkenazi Jewish descent?
Y / N	Are you concerned about your personal and/or family history of cancer?
Y / N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (please explain/include results if possible)

Hereditary Cancer Red Flags: Personal and/or family history of any one of the following:

_	**Multiple** A combination of cancers on the same side of the family:	• **2 or more:** breast/ovarian/prostate/pancreatic cancer • **2 or more:** colorectal/endometrial/ovarian/gastric/pancreatic/other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) • **2 or more:** melanoma/pancreatic
_	**Young** Any 1 of the following at age **50 or younger:**	• Breast cancer • Colorectal cancer • Endometrial cancer
_	**Rare** Any 1 of these rare presentations at **any age:**	• Ovarian cancer • Breast: Male breast cancer or Triple negative breast cancer • Colorectal cancer with abnormal MSI/IHC, or MSI associated histology • Endometrial cancer with abnormal MSI/IHC • 10 or more colorectal polyps

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**

Authorization of Use and Disclosure of Protected Health Information

I, _____, give Monarch Healthcare authorization to use and/or disclose my protected health information to the individuals listed below (doctor's office, parent, spouse). I understand if their names are not listed below, no information will be shared without a signed consent.

Name	Relationship to Patient	Phone number

This authorization shall remain in effect until revoked or terminated by the patient or the patients parents personal representative. You may revoke or terminate this authorization by submitting a written revocation to Monarch Healthcare.

Alternate Means of Communication

You may request to receive confidential communications involving your protected health information by alternative means. Please list below the numbers at which you would like to be contacted and indicate at which at which number(s) messages may be left by checking the "Message Ok" box.

Home: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Work: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Cell: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Fax: (__ __ __) ___ ___ ___ -___ ___ ___ ___ Message Ok ☐

Other:_____

Signature:_____ Date:_____

Relationship if representative:_____