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

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

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

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 and lab tests, 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. Monarch may also bill your lab work to your insurance depending on your carrier.

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 10% per month begins accruing after 90 days on any unpaid balances.
RETURNED CHECKS: A $20.00 fee will be charged for all returned checks not honored by your bank.
COLLECTIONS/BANKRUPTCY: ***If your account is sent to collections or bankruptcy 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, and/or 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:_____

Monarch Healthcare
Delivering tomorrows promises, today.

Medical Update Form

Name: _____ **DOB:** _____

Pharmacy: _____

Last menstrual period: _____

***Who should we thank for referring you?** _____

Daily Meds (OTC/RX)	Dose	Frequency

Allergies: _____

New Medical Diagnosis's/Surgery/Treatment	

Problems you would like to discuss today: _____

_____

_____

Patient Signature: _____ **Date:** _____