## Patient Information

**Legal Name**: **Middle Initial**:

**Preferred Name**: **Primary Care Provider:**

**Birth Date**: **Social Security Number**:

**Home Phone**: **Cell Phone**:

**Marital Status**: ❑ Common Law ❑ Divorced ❑ Legally Separated ❑ Widowed ❑ Life Partner ❑ Married ❑ Single

**Gender**: ❑ Male ❑ Female

**Email address**:

**Street Address**: **Apt or Unit**:

**City**: **State**: **Zip Code**:

**Emergency Contact**:

**Relation**: **Phone**:

**Race**
❑ African American
❑ Alaska Indian
❑ Asian
❑ Caucasian
❑ East Indian
❑ Other:
❑ Hispanic
❑ Native American
❑ Oriental
❑ Pacific Islander
❑ Declined

**Ethnic Origin**
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Declined

**Primary Language**
❑ English
❑ Spanish
❑ Other:

**Employment Status**: ❑ Full Time ❑ Part Time ❑ On Active Military Duty ❑ Self Employed ☑ Retired ❑ Student ❑ Disabled

**Employer Name**:

**Employer Address**:

**City**: **State**: **Zip Code**:

## Guarantor and/or Insurance Policy Holder Information

*Please fill this out if you are a minor and/or your insurance coverage is through a spouse*

**Legal Name**: ❑ Guarantor ❑ Policy Holder

**Birth Date**: **Social Security Number**: **Relationship:**

## Please provide Insurance Cards and a form of Photo Identification

X _____

*Signature*

_____

*Date*

Portneuf MEDICAL GROUP

Date _____

Patient Name _____ Patient No. _____

## CONSENT TO MEDICAL AND SURGICAL TREATMENT

I voluntarily consent to care and treatment of the Patient by PORTNEUF MEDICAL GROUP and its affiliated physicians, practitioners, and staff, including but not limited to outpatient medical, surgical, nursing, and therapeutic care; diagnostic, laboratory, and radiological tests and procedures; administration of pharmaceuticals or anesthesia; and such other care as deemed reasonably necessary or advisable by the attending physician, practitioner or staff member. I understand that PORTNEUF MEDICAL GROUP may photograph or video the Patient to assist PORTNEUF MEDICAL GROUP in providing treatment for the Patient and I hereby consent to same. If PORTNEUF MEDICAL GROUP personnel suffer a needle stick or are exposed to blood or body fluids, I consent to the testing of the Patient for any blood-borne disease for the protection of PORTNEUF MEDICAL GROUP personnel.

## ADVANCE DIRECTIVES

Please indicate whether the Patient has executed an advance directive, e.g.: ❑ Living Will ❑ Durable Power of Attorney ❑ POST
❑ Other (describe):_____.
I understand that it is PORTNEUF MEDICAL GROUP's policy not to comply with advance directives that would prohibit life sustaining treatment. I consent to such treatment on behalf of the Patient, and agree that any contrary directions in the Patient's advance directives shall be suspended while the patient receives care at PORTNEUF MEDICAL GROUP.

## COMMUNICATION PREFERENCES-PORTNEUF MEDICAL GROUP

I agree the PORTNEUF MEDICAL GROUP may communicate with me in writing to any address I have provided, may communicate with me orally or by text message to any telephone number I have provided, and may communicate with me electronically to any email address I have provided.

My preferred method of communication is (check one): ❑ Cellular phone ❑ Home Phone ❑ Work Phone

Medical information and test results may be left on my answering machine and voice mail (Check one): ❑ Yes ❑ No

## CONDITIONS FOR TREATMENT AT PORTNEUF MEDICAL GROUP

In consideration for the care and treatment that Patient will receive or has received at PORTNEUF MEDICAL GROUP, I agree to the following:

1. **Patient Responsibilities.** I agree to comply with the Patient Responsibilities set forth in PORTNEUF MEDICAL GROUP's separate Notice of Policies, Patient Rights, and Patient Responsibilities..
2. **Payment.** I agree that I am responsible for any co-payments, deductibles or other charges for services to the Patient that are not paid by insurance, government programs, or other payers, except as prohibited by applicable law or any agreement between my insurance company and PORTNEUF MEDICAL GROUP. I agree to make such payments according to PORTNEUF MEDICAL GROUP's regular terms of payment. Where appropriate, I agree to submit and cooperate with PORTNEUF MEDICAL GROUP in submitting claims to entities from which payment may be obtained, including any government program, insurance company, or other third parties. I understand that I will remain responsible for any amount not paid by insurance or a third party. If the Patient's account becomes delinquent, I agree to pay interest and fees according to PORTNEUF MEDICAL GROUP's policies, including but not limited to reasonable costs of collection, collection agency fees, attorney's fees, and court costs. I agree that any overpayments collected for Patient's admission or treatment on this occasion may be applied directly to any delinquent account of Patient.
3. **Assignment and Authorization.** I hereby assign and authorize direct payment to PORTNEUF MEDICAL GROUP of any payments or other benefits to which I or the Patient may be entitled from any government program, insurance company, or other entity that is or may be liable for costs associated with Patient's care. I agree that this assignment will not be withdrawn or voided at any time until Patient's account is paid in full. To the extent such authorization is required by applicable regulations, I hereby authorize Portneuf Medical Group or any other holder of medical information about the Patient to release such information to the Centers for Medicare and Medicaid Services and its agents as necessary to determine benefits payable for services provided to Patient. This authorization shall not modify or limit Portneuf Medical Group's right to use or disclose protected health information as otherwise allowed by applicable law or Portneuf Medical Group's Notice of Privacy Portneuf Medical Groups.

4. **Billing Portneuf Medical Group.** I understand and agree that any quote of charges for services rendered and/or insurance benefits available are estimates based upon the best information available at the time. PORTNEUF MEDICAL GROUP may amend such quotes and I will be responsible for charges for services actually rendered. I understand and agree that PORTNEUF MEDICAL GROUP will require payment of all accounts at the time the services are rendered unless PORTNEUF MEDICAL GROUP has expressly agreed to contrary arrangements. Where insurance is available, PORTNEUF MEDICAL GROUP will bill and allow a reasonable time for the insurance company to pay. I will be responsible for any amount not covered by insurance. Should payment not be received, the Patient and I will be billed for all charges and interest. Payment is due upon receipt of the bill.

## PERSONAL PROPERTY

I understand and agree that PORTNEUF MEDICAL GROUP does not assume any responsibility for my personal property and shall not be liable for any loss or damage to such personal property.

## NO GUARANTEE

I understand and agree that the practice of medicine is not an exact science and that no guarantees have been made to me regarding the results of Patient's care or treatment at PORTNEUF MEDICAL GROUP.

## PERSONS FOR WHOM PORTNEUF MEDICAL GROUP IS NOT LIABLE.

I understand that PORTNEUF MEDICAL GROUP is only responsible for the acts of its employees acting within the scope and course of their duties. I understand that persons who are not employed by PORTNEUF MEDICAL GROUP may be involved in my care or treatment, including but not limited to other practitioners, laboratories, diagnostic testing facilities, contractors, vendors, product technicians, etc. I understand that PORTNEUF MEDICAL GROUP is not liable for the acts or omissions of non-employees or PORTNEUF MEDICAL GROUP employees acting outside the course and scope of their duties.

## NOTICE OF PRIVACY PRACTICE

I have received a copy of PORTNEUF MEDICAL GROUP's Notice of Privacy Practice on this or a prior occasion. [Please Initial]: _____

## NOTICE OF PATIENT RIGHTS AND PATIENT RESPONSIBILITIES

I have received a copy of PORTNEUF MEDICAL GROUP's Notice of Policies, Patient Rights & Responsibilities on this or a prior occasion. [Please initial]: _____

I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative, and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

| Print Name | Date | Time |
|---|---|---|
| Signature | Date | Time |
| Relationship to Patient/Authority | Date | Time |