IDAHO
SLEEP HEALTH

PATIENT INFORMATION

PLEASE FILL OUT ALL INFORMATION
PLEASE USE BLACK OR BLUE PEN

Name:	Date of Birth:
Address:	Age:
City/State/Zip:	Marital Status: S M D W
Social Security#:	Cell Phone:
Home Phone:	Work Phone: Ext:
Patient Employer:	Email:
Occupation:	Spouse/Guardian:
Spouse/Guardian Employer:	Spouse/Guardian Phone Number:

INSURANCE

- Primary Insurance Provider: _____
- Insurance ID #: _____
- Group #: _____
- Subscriber Name: _____ Birth Date of Subscriber: _____

- Secondary Insurance Provider: _____
- Insurance ID #: _____
- Group #: _____
- Subscriber Name: _____ Birth Date of Subscriber: _____

Referring Physician: _____
Primary Care Physician: _____
Referred By (if other than a Physician): _____

Please list the name of someone who we may contact in case of an emergency:

Name: _____ Relationship: _____ Phone: _____

I authorize Idaho Sleep Health to release my medical records to my insurance company and other medical providers.

Signature: _____ Date: _____

*****PLEASE ALSO READ AND SIGN THE BACK OF THIS FORM*****

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Our Financial Policy

Thank you for choosing Idaho Sleep Health. We are committed to providing you with the very best medical care we have available. Please understand that payment for this medical care is your responsibility. The following is a statement of our Financial Policy, which prior to the rendering of any treatment, must be read, agreed to and signed. This Financial Policy applies only to services rendered by Idaho Sleep Health. A separate charge from Dr. Mark Rasmus may apply for interpretation services on sleep studies.

New patients with no insurance coverage are expected to pay a minimum $200.00 deposit toward their services. Existing patients with no insurance coverage are expected to pay a minimum of $100.00 deposit toward their services. These deposits are due at the time the appointment is scheduled.

It is the patient's responsibility to verify their benefits for their particular insurance plan and to make sure all of the proper authorizations/referrals have been obtained. Some insurance plans will reduce benefits of the insured if treated by a provider outside of the designated network or if the proper authorizations/referrals have not been obtained. It is your responsibility as a patient to tell us in advance if your insurance company requires pre-authorization of procedures. Please keep us informed of insurance changes.

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT (ALL PATIENTS MUST SIGN)
I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any applicable deductible, co-insurance or co-pay, as well as any services deemed as "non-covered benefit" by my insurance carrier. I acknowledge that payment in full is expected within 90 days of the first patient statement date. If I am unable to make full and complete payment within 90 days, I agree to call the billing office of Idaho Sleep Health at (208)327-6440 and arrange for payment options through either Health One© or Account Billing Services (ABS). Health One© pamphlets are available upon request. Payment arrangements may be set up with ABS for a $20.00 set up fee and finance charge (1.0% per month/APR 12%). (Medicare patients will not be charged the set up fee or finance charge). If payment arrangements cannot be agreed upon, the amount due will be considered delinquent and may be subject to legal action or assignment to a collection agency. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. In consideration for medical services rendered, I acknowledge that I have received notice of Idaho Sleep Health's Financial Policy and agree to pay for said medical services according to such terms.

Please refer to our HIPAA Notice of Privacy Practices for a complete list of permitted uses and disclosures of your Protected Health Information (PHI). You have the right to review our Notice of Privacy Practices prior to signing this consent form. There may be a revision of our Notice of Privacy Practices since you were last here. If this is the case, please review the current one and sign it. The latest version is always available upon request. You may request to restrict the use or disclosure of your protected health information for treatment, payment or health care operations; however, we are not obligated to comply with that request. We will be bound by the restrictions you outline only if we agree to those restrictions. You have a right to revoke your consent in writing at any time, but the revocation will have no effect on any actions we took in reliance on the consent before the revocation.

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE/CONSENT FOR TREATMENT (All Patients).
With this form (or a photostatic copy of it), I authorize the release of any medical or other information acquired in the course of my treatment to my insurance carrier, practitioners involved in my care at Idaho Sleep Health and their agencies and to outside providers of my care. I understand that in the release of this information it may be transmitted via voice, hard copy, fax, e-mail, electronic insurance send, phone transmission or data line transmission.

Medical treatment and financial billing information is confidential and re-disclosure is prohibited. I authorize assignment of insurance benefits to be paid directly to Idaho Sleep Health for all medical services rendered. I hereby consent to any medical treatment, lab or other procedure, which the providers(s) may consider or advise in treatment of my case (or as legal guardian for patient). This signature represents that I have read and agree to the above policy. Failure to sign this authorization would result in our being unable to provide services for you.

Patient name (please print):_____

Signature:_____(patient or guardian) Date:_____

MEDICARE/MEDICAID PATIENT AGREEMENT (For Medicare and Medicaid Patients Only)
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Idaho Sleep Health for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. Failure to sign this authorization would result in our being unable to provide services for you.

Signature: _____ Date: _____