Vista Healthcare
570 Trejo St.
Rexburg, ID 83440

Preferred Primary Care Provider: ___ Rachelle Jones or ___ Rebecca Jeppson or ___Marquee Ricks

Patient Information

Last Name _____ First Name _____ MI _____
Address _____ City _____ State ____ Zip _____
Home Phone _____ Cell Phone _____ Birth Date _____
Gender ____ Marital Status _____ SS# _____ Race/Ethnicity _____
Language _____ Email Address _____ Access to Patient Portal? **Y N**
Employer_____ Address _____ Phone_____
Name of Spouse _____ Birth Date _____ Phone _____
Address (If Different) _____ City _____ State ____ Zip ___

Emergency Contact: _____ Relationship to patient _____
Address _____ Phone number _____

Primary Insurance: _____ ID # _____ Group # _____
Policy Holder Name _____ Birth date _____ Phone _____
Policy Holder's Address _____ City _____
State _____ Zip_____ Patient Relationship to Insured _____Financial responsibility? **Y N**

Second Insurance: _____ ID # _____Group # _____
Policy Holder Name _____ Birth date _____ Phone_____
Policy Holder's Address _____ City _____
State _____ Zip_____ Patient Relationship to Insured _____ Financial responsibility? **Y N**

Preferred Pharmacy _____ City_____

Parents Information (For Minors and BYU-ID students)
(If BYUI student, please provide primary address here, if different from above)

Father's Name _____ Birth Date _____
Address _____ City _____ State ____ Zip _____
Phone_____ Financially Responsible Party? **Y N**
Mother's Name _____Birth Date _____
Address _____City _____ State _____ Zip_____
Phone _____ Financially Responsible Party? **Y N ____**

AUTHORIZATION TO PAY AND RELEASE INFORMATION
I hereby authorize **Vista Healthcare** to provide any medical care deemed necessary according to their professional opinions. I authorize my insurance benefits to be paid to **Vista Healthcare**. I authorize the release of any information to my insurance carrier pertinent to my health insurance claim. I understand that I am financially responsible for my account which includes co-payments (due at the time of service), annual deductibles, or percentages not covered by my insurance plans. I also understand that it is my responsibility to be familiar with my insurance benefits and to give accurate information for billing purposes. Delay in billings due to inaccurate information may result in a rebilling fee or the balance due by me. Also, that on my behalf are the responsibilities for certain services such as family or telephone conferences. Services not eligible for benefits such as tests or procedures that the physician determines medically necessary, but are later deemed unnecessary by my insurance plan, are ultimately my responsibility. If this is a financial burden, a payment plan must be arranged with the Accounts Coordinator. When payments are not made as promised, or are over 60 days old the balance is subject to interest and finance charges in accordance with the state and local laws. Accounts over 120 days with no payments made or three consecutive months of no payment made will be turned over to a collection agency.

Patient Signature (or Guardian) _____ date_____

Please print name _____

Rachelle Jones FNPc
Rebecca Jeppson FNPc
Marquee Ricks FNPc

PERSONAL MEDICAL HISTORY

NAME: _____DATE OF BIRTH: _____TODAY'S DATE:_____

Reason for Visit: _____

Have you ever had any of the following conditions? (Check if yes)

- ☐ Asthma
- ☐ Angina/chest Pain
- ☐ Anemia
- ☐ Arthritis
- ☐ Glaucoma
- ☐ Chronic Bronchitis
- ☐ Cirrhosis
- ☐ Clotting Disorders
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gall Stones
- ☐ Heart Attack
- ☐ Cancer – Please List Below
  _____
  _____
- ☐ Heart Murmur
- ☐ Headaches
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV positive AIDS
- ☐ Kidney Stones
- ☐ Migraines
- ☐ Positive TB
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Ulcers
- ☐ Other – Please List Below
  _____
  _____
  _____

Past Surgical History

Have you ever had surgery? ☐ Yes ☐ No
If yes, please list:
Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____
Recent Hospitalization: _____
_____

Health Maintenance

Date of last PAP : _____
Date of last Menstrual Cycle: _____
Previous Mammogram: _____
Previous Colonoscopy: _____

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No
Please list: _____
Are you allergic to latex? ☐ Yes ☐ No
Are you allergic to any foods? ☐ Yes ☐ No
Please list: _____

Family History

If any blood relative has ever had any of the following, please check box and indicate the relationship.

- ☐ Bleeding Tendency _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart Attack _____
- ☐ Heart Disease _____
- ☐ High Blood Pressure _____
- ☐ Kidney Disease _____
- ☐ Liver Disease _____
- ☐ Migraine Headaches _____
- ☐ Stroke _____
- ☐ Tuberculosis _____

Medications:

List all medications and supplements you take:

Medicine or Supplement	Dosage?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preferred Pharmacy _____

Vista Healthcare

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I choose) and understand the notice.

_____ _____
Patient Name (please print) Date

_____
Parent or Authorized Representative (if applicable)

_____
Signature

Authorization To Leave a Message

I authorize Vista Healthcare providers or staff to leave a message with a responsible family member or on an answering machine concerning my health care.

Signature _____ Date _____

OR

I **DO NOT** authorize Vista Healthcare providers or staff to leave a message with a responsible family member or on an answering machine concerning my health care.

Signature _____ Date _____

Rachelle Jones FNPc

Rebecca Jeppson FNPc

Marquee Ricks FNPc

Welcome

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we adopted the following policies.

Fee and Payments

- Fees are based on a standard commercial, government, or self-pay fee schedule.
- Payments are adjusted according to contracted prices with insurances.
    - Exceptions Advance beneficiary notices
- Self-pay fee schedule offers an added 20% discount on office visit evaluation and treatments codes if paid at the time of service.
- Charges are based on the complexity of your visit.
- Payment in full is required at the time of your visit and can be made with cash, personal check, money order, Visa, MasterCard and Discover.
- Insurance co-payments are due at the time of service. If you have a secondary insurance that will pay your copays we will as a courtesy to you bill them for the copay and remainder of your balance. However, please be familiar with your insurance benefits. If your secondary does not cover copays, we expect you to pay at the time of service. If you are uncertain of your benefits the copay will be expected. We reserve the right to charge a copay service charge to your account of $20 if copays are not paid at the time of service.
- While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Having insurance is not a guarantee that the service rendered with our providers is payable. Payments are subject to plan benefits, eligibility, co-insurance, deductible, provider contract, medical necessity including plan limits. etc.
    - Before your visit, contact your insurance company to verify that we are participants in your plan. Insurances are plan specific; we may participate with the insurance company but not all plans.
    - Check to make sure the services you are seeking are a covered benefit. Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. Insurances select certain services that they will/will not cover based on medical necessity, therefore we cannot guarantee payment of all claims by your insurance resulting in the remainder of the charges to be the responsibility of the patient.
    - You must present a current copy (front and back) of your insurance cards.
    - If you are a member of a Medicare program, we still require a copy of you Medicare card along with the Advantage Card
- We strive to keep accurate insurance and your personal information on file; however, it is ultimately your responsibility to make sure that you give us accurate information and inform us of any changes to your personal demographics that may affect timely filing, incorrect claims submission, or returned statements etc.
- You will be informed of any claim submission errors that result from inaccurate information on your monthly statement or by mail. We encourage you to pay particular attention to your statements or correspondence from us and call or go to our website (patient portal) to make changes that will rectify the problem.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made on medical information presented at the time of service; NOT based on coverage by

Insurance Companies. To request a diagnosis, change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and considered insurance fraud.

Required at Check-In

1. Verify Personal Contact Information
2. Present current copy of insurance card
3. Present current Picture ID
4. Payment of any outstanding balance.
5. Payment of today's visit.

We will strive to verify coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for the payment of your visit. We will submit the claim to the insurance on file and if payment is made resulting in an overpayment a check will be issued to you.

Self- Pay

In order to address the needs of our patients without insurance or those who only carry catastrophic policies, or coverage limitations, we offer a 20% discount on office visit evaluation and treatment codes. This discount acknowledges the lower cost involved in billing and collections when a claim does not need to be submitted to a second or third-party payer. However, procedures are discounted on the fee schedule level and are not subject to a further discount. Our providers are very mindful of patients paying out of pocket and strive to keep costs down without sacrificing care. In order to benefit from this discount, the payment needs to be made in full at the TIME OF SERVICE. Any remaining balance is not eligible for a discount.

MEDICARE P art B / Medicare Advantage programs

We gladly accept Medicare part B patients and bill out services as a courtesy to the patient.

- Medicare patients that have supplement insurance are not required to make a payment at the time of service. However, not all supplements pay for Medicare deductibles or coinsurance portions. Please be informed what your secondary benefits are.
- Medicare Patients are required to present their card at each visit. Patients enrolled in an Advantage program will need to provide the commercial product card and their Medicare card.
- Occasionally a patient will present a Medicare Advantage HMO product, if the patient is enrolled with a provider outside of our clinic, they may have a higher deductible.
- Medicare patients that have Medicaid as their secondary or tertiary insurance any portion remaining is the responsibility of the patient.

Medicaid / Dual Medicaid / Medicaid Managed care (non-contracted)

- Vista Healthcare and the providers are non-contracted with Medicaid or any of its affiliated products. This includes but not limited to: Healthy Connections, Secondary to a commercial insurance any Dual Medicaid products and outside of Idaho Medicaid.
- Idaho Medicaid prohibits their insureds to be seen on a cash basis for covered items.

Divorce

In the event of divorce, we will try to extend every courtesy to you in dealing with your divorce decree. However, we cannot become party to your degree. Adult patients are responsible for accurate insurance information, copies of cards, and payments on their accounts. The responsibility of minor's rest with the accompanying adult, or residing parent or guardian, we will not contact the spouse for payment or patient information pertaining to insurance or demographics needed to complete claim submission.

International Student

Payment is expected at the time of service in full. We do not verify coverage or claim to accept International Student Insurance Plan. We will collect the information and submit the claim according if payment is made an overpayment check will be refunded to the paying party.

Workers Compensation/ Accident Insurance

Patients presenting with injuries must fill out an accident form. If the patient requests us to file a worker's compensation or accident policy, they must provide the insurance to be filed along with the claim number, address and phone number. In the event that the claim is denied the patient will be responsible for payment.

Annual/ Wellness/ Preventative Visits

Please verify that your insurance will cover these preventative services and that you have met the timely file stipulations before making your appointment. Coverage may depend on age, sex, social family history etc. not all benefits are covered under all insurance carriers. Please be familiar with the services that accompany this benefit.

***PLEASE NOTE*:** Annual/wellness/Preventative visits are subject to presenting complaints. Illness presenting with annual/wellness or preventative visit may not qualify for that visit to be coded as an Annual/wellness or preventative visit therefor subjecting that patient to a payment they may not be expecting.

Miscellaneous Charges

- Return Check Charges: are subject to a $25.00 fee. Nonpayment will result in the account be turned to collections.
- Collections: Accounts that are not paid in 90 days will be turned to collections.
- Accounts that go 3 consecutive months without a payment will be turned to collections.
- Statements that have been returned by postal carrier will be turned to collections.
- 3 missed or no-show visits will be subject to fee.

Hormone Pellet Implantation (testosterone, estrogen) Bio Identical

Hormone Pellet implantation is considered investigational by most insurances resulting in a denied claim or underpaid. Payment is required at the time of service. You will be required to sign an advance beneficiary notice explaining the cost of the procedure, at every visit. Your insurance can be billed as per our contract with insurances, and networks. A credit can be applied towards future visits, but only by a patient payment. Insurance payments cannot be distributed to different claim dates of service even if they result in an overpayment.

Contraceptives

Due to the expense of contraceptive devices, i.e. IUD's, drug implantations, a benefit investigation will be done as a courtesy to you to determine your unique insurance benefit. You will be required to sign an advance beneficiary notice explaining the cost of each device and procedure. You will be responsible for any remaining cost of the device not covered by your insurance plan regardless of plan benefit, prior approval, or unforeseen circumstance. The procedure or outcomes from consent to preform are subject to co-insurance and deductibles.

Lab/ Pathology

You will receive a separate billing from the laboratory/pathologist.

Accounting Principals

Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of services.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient or Guarantor, if applicable	Date
Please PRINT Signature of Patient or Guarantor	Please Print Patient name if minor or other than Guarantor

Rachelle Jones FNPc
Rebecca Jeppson FNPc
Marquee Ricks FNPc

Notice of Separate Billing

Your Provider may order laboratory and/or Imaging services for you during your visit. These services are needed to help the provider to:

- Screen for new illness, or condition.
- Monitor chronic illness.
- Diagnosis an illness, or condition.
- Change, continue, or start treatment of illness or condition.
- To establish baselines or verify abnormal results.
- **Patient request.**

Although the orders for the tests are generated by your provider in this clinic, you will receive a separate bill from the facility that preforms the test.

List of frequently used testing facilities:

- Express Labs – 208-529-8330
- Madison Memorial Lab – 208-359-6442
- Madison Memorial Radiology – 208-359-6508
- Teton Radiology Madison – 208-359-4888
- Teton Radiology Idaho Falls – 208-524-7237
- Coles Diagnostic – 800-850-7284 (pathology)
- East Idaho Reg. Med. Ctr. Lab – 208-529-6040
- East Idaho Reg. Med. Ctr. Radiology – 208-227-2600
- Lab Corp – 206-244-7900
- Quest Diagnostic – 208-552-4826

Insurances have continued to change, update, and adjust payment for Laboratory/Radiology services, pending on plan benefits. Please contact the billing facility directly for questions regarding your bill. These services are subject to preventative, deductible, benefit levels and contracted allowables. It is impossible for the ordering provider to keep up with all insurance plans and benefits for these services. If you are concerned about the charges, we encourage you to contact your insurance plan and find out your coverage details. Our providers will try to alert you to possible unexpected charges, however even the most common and basic services have been affected by these changes.

Listed below are **general guidelines** for most insurances.

All insurances require a provider to meet medical necessity for coverage determination.

- Screenings – classified as preventative (see your plan guidelines for coverage details on screening services.) must meet medical necessity and risk. Medicare does not pay for screening codes.
- Monitor chronic illness – if patient is diagnosed with an illness, or being treated for an illness, services are subject to insurance plan benefits.
- Diagnosis purposes are subject to plan benefits.
- Treatment purposes are subject to plan benefits.
- Baselines and confirming results are subject to plan benefits.
- Patient request – no "medical necessity" is responsibility of patient.
- Some imaging and some lab tests will require prior authorization before services will be performed.
- Genetic blood test is general not covered and will require the patient signature to process the test, stating that they are aware that this test may not be covered, and they are responsible for the payment. (Below: list of most common test ordered)
    - MTHFR - $100.00 - $200.00
    - Factor Five - $155.00

List is not inclusive and does not guarantee payment or insurance coverage.

Labs, and or imaging are ultimately the responsibility of the patient, please be familiar with your insurance plan and plan contact information.

Patient signature: _____ Date: _____

Print signature: _____

*Form needs to be signed annually and copy provided to patient