TETON CANCER INSTITUTE
trusted, for life.

Welcome!

We are honored that you have chosen us to help with your healthcare needs. We look forward to meeting you at your upcoming office visit! We are an affiliate of Mountain View Hospital in Idaho Falls.

Please plan to arrive 1 hour before your scheduled appointment time to complete necessary paperwork. This helps us to correctly establish your patient chart. Your first appointment with us will likely last between 1-1 ½ hours.

We make every attempt to remain on schedule. However, due to the nature of our work, some of our patients need extra time and care from our staff and there are times that we may run behind. We ask that you please be patient if this happens. We are doing our best to ensure that each patient gets the care and attention that they need. Due to our high number of patients, we ask that you bring no more than 2 other people to your appointment.

With this letter, you will find a new patient packet. It includes a lot of detailed questions to ensure that our doctors are able to view as much of your medical history as possible. We understand that you may not have all of the information, but please fill it out to the best of your ability and sign the appropriate forms. Please bring the completed packet to your appointment with your insurance card and photo ID. Also bring any medical records that you have related to the problem we are seeing you for unless arrangements have made for them to be sent to us. These include doctor's notes, lab work, radiology reports, and pathology reports.

Insurance information: We will bill your insurance as a courtesy. If you have medical insurance, your insurance company will be billed after deductibles and copayment requirements have been met. *We are required to collect all co-pays at the time of your visit.* You are responsible for prompt payments of any amounts not covered or paid by your insurance carrier, including deductible amounts. If you do not have insurance or only have a primary carrier, or need more assistance with payment options, we are pleased to offer a patient financial coordinator to assist you.

If there is an outstanding balance, we will mail a monthly statement to you at the address you have given us. Regular monthly payments are necessary in order to keep your account in good standing. If you have any concerns about this, please contact Mountain View Hospital billing department at (208) 557-2709.

Thank you for taking the time to review and complete this packet. We will see you soon. If you have any questions or concerns, please contact our office and ask to speak to one of our new patient coordinators for assistance.

Sincerely,

The Staff of Teton Cancer Institute

Mountain View Hospital
Getting you back to what you Love

1957 East 17th St., Idaho Falls, ID 83404
Office: (208) 523-1100 Fax: (208) 523-1317

380 Walker Drive, Rexburg, ID 83440
Phone: (208) 356-9559 Fax: (208) 356-6601

TETON CANCER INSTITUTE
trusted, for life.

TETON CANCER INSTITUTE
AN AFFILIATE OF MOUNTAIN VIEW HOSPITAL

Patient Information

Name:_____ _____ _____ **Preferred Name:**_____
Last **First** **MI**

Birthday:_____ **Age:**_____ **SS#:**_____ **Gender:**_____

Mailing Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Phone Number:_____ **Employer:**_____ **Work Phone:**_____

Email:_____

Accident or Injury: Yes NO **Religion:**_____ **Ethnicity:**_____ **Race:**_____

Spouse/Guardian Information:

Marital Status:_____

Name:_____ **Relationship to Patient:**_____

Address (If different than Patient's):_____

Birthday:_____ **Phone Number:**_____

Emergency Contact Information

Name:_____ **Relationship:**_____ **Phone Number:**_____

Primary Care Physician:_____ **Referring Physician:**_____

Pharmacy of Choice:_____

Insurance Information

Primary Insurance Company:_____ **Policy Holder's Employer:**_____

Policy Holder:_____ **Birthday:**_____ **Group Number:**_____

Secondary Insurance Company:_____ **Policy Holder's Employer:**_____

Policy Holder:_____ **Birthday:**_____ **Group Number:**_____

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TETON CANCER INSTITUTE *trusted, for life.*

Please tell us about the condition we are seeing you for today.

What problem(s) are you having?
When did it start?
What symptoms have you had?
Are you still having these symptoms?
Does anything make it better or worse?
Does it come and go or is it constant?
Have you had surgery for this? (date, surgeon, facility)
Office use only

Have you had any of these conditions?

	Date of Onset			Date of Onset	
□ Angina		□Ongoing □Resolved	□ High blood pressure		□Ongoing □Resolved
□ Asthma		□Ongoing □ Resolved	□ Inflammatory bowel disease		□Ongoing □ Resolved
□ Congestive heart failure/pulmonary edema		□Ongoing □ Resolved	□ Kidney disease		□Ongoing □ Resolved
□ Degenerative joint disease/osteoarthritis		□Ongoing □ Resolved	□ Osteoporosis		□Ongoing □ Resolved
□ Diabetes □ *Type 1* □ *Type 2*		□Ongoing □ Resolved	□ Parkinson's disorder		□Ongoing □ Resolved
□ Emphysema/COPD		□Ongoing □ Resolved	□ Phlebitis		□Ongoing □ Resolved
□ Epilepsy/seizure disorder		□Ongoing □ Resolved	□ Pneumonia		□Ongoing □ Resolved
□ Heart attack / myocardial infarction (MI)		□Ongoing □ Resolved	□ Rheumatoid arthritis Where?		□Ongoing □ Resolved
□ Hepatitis/Cirrhosis		□Ongoing □ Resolved	□ Stroke		□Ongoing □ Resolved
□ High blood pressure		□Ongoing □ Resolved	□ Thyroid disease		□Ongoing □ Resolved
□ Inflammatory bowel disease		□Ongoing □Resolved	**Comments :**		
□ Kidney disease		□Ongoing □ Resolved			

Other Medical Problems

Problem	Treating Physician	Comments
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Malignancy History

Type of Cancer & Where	Date of Onset		Comments
		□Ongoing □Resolved	
		□Ongoing □ Resolved	
		□Ongoing □ Resolved	
		□Ongoing □ Resolved	

Hematological History (includes anemia, hemochromatosis, deep vein thrombosis, and any other blood disorders)

Have you ever had: Blood transfusion: Yes□ No□ Abnormal clotting: Yes□ No□ Abnormal bleeding: Yes□ No□

Problem	Date of Onset		Comments
		□Ongoing □ Resolved	
		□Ongoing □ Resolved	
		□Ongoing □ Resolved	
		□Ongoing □ Resolved	

Office use only

Surgical History

Type of Surgery/Part of Body	Date	What was it for?	Surgeon/Facility

Office use only

Family History (please include whether the family member is on your mother or father's side. We are especially interested in family members with a history of cancer or blood disorder.)

□ *I am adopted and unsure of my biological family's medical history*

Relationship to you	Problem	Age of onset	Comments (alive/deceased)

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Health Maintenance

Date of last flu vaccine:	□ I've never had this vaccine
Date of last pneumonia vaccine:	□ I've never had this vaccine
Date of last sigmoidoscopy/colonoscopy:	□ I've never had this procedure

Women

Gynecologist:	Facility:
Date of last mammogram:	Date of last gynecologic exam:
Age at first period:	Age at menopause: Reason:
Age at first birth:	Total # of pregnancies:
# of live births:	# of interrupted pregnancies:
Did you breastfeed?	

Have you ever used hormonal contraceptives (pills, patch, injection, vaginal ring)? Yes □ No □
Are you currently using them? Yes □ No □ If yes, for how long? _____

Have you ever had hormone replacement therapy (HRT)? Yes □ No □
Are you currently using it? Yes □ No □ If yes, for how long? _____

Have you had any of the following problems? □ Heavy menstrual flow □ Miscarriage □ Uterine fibroids

Men

Date of last digital rectal exam:		□ I've never had this procedure
Date of last PSA test:		□ I've never had this test

Office use only

Social History

Occupation: □ Full time □ Part time □ Unemployed □ Retired

□ I cannot receive blood products for religious reasons □ I cannot receive blood products for other reasons

Have you been exposed to:
□ Asbestos □ Ionizing radiation (does not include X-rays) □ Toxic chemicals such as industrial solvents or PCBs

Tobacco/Nicotine	Are you currently using tobacco/nicotine? Yes□ No□		□ I've never used tobacco/nicotine
□ Cigarettes	□ Cigars/Pipe	□ Snuff/Chew	□ Electronic cigarettes/Vape
Packs per day:	How often? _____	How often? _____	How often? _____
When did you start?		If you quit, when?	

Alcohol	Are you currently using alcohol? Yes□ No□		□ I've never used alcohol
□ Beer	□ Wine	□ Liquor	If you quit, when? _____

On average, how many drinks do you have: Per day: Per week: Per month: □ Less than 1 drink monthly

Recreational drugs	Are you currently using recreational drugs? Yes□ No□		□ I've never used recreational drugs
□ Marijuana	□ Cocaine	□ Heroin	□ Amphetamines
□ Narcotics	□ Other:	□ Other:	If you quit, when?

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Allergies

Medications	Type of Reactions

Medication and Supplement List

Name of Medication	Dose	Directions for Taking	What is this for?	Prescribing Physician

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Have you had any of these symptoms?

General		Gastrointestinal	
Weight loss (unexpected)	□Ongoing □ Resolved	Frequent diarrhea	□Ongoing □ Resolved
Weight gain (unexpected)	□Ongoing □ Resolved	Frequent constipation	□Ongoing □ Resolved
Fever	□Ongoing □ Resolved	Bloody/tarry stool	□Ongoing □ Resolved
Fatigue	□Ongoing □ Resolved	Nausea/vomiting	□Ongoing □ Resolved
Headache	□Ongoing □ Resolved	**Genitourinary**	
Eyes		Blood in urine	□Ongoing □ Resolved
Double vision	□Ongoing □ Resolved	Painful urination	□Ongoing □ Resolved
Spots in vision	□Ongoing □ Resolved	Unable to empty bladder	□Ongoing □ Resolved
Vision changes	□Ongoing □ Resolved	Stress incontinence	□Ongoing □ Resolved
ENT/Mouth		Vaginal bleeding/discharge	□Ongoing □ Resolved
Earaches	□Ongoing □ Resolved	Vaginal lesions	□Ongoing □ Resolved
Ringing in ears (tinnitus)	□Ongoing □ Resolved	**Musculoskeletal**	
Sinus problems	□Ongoing □ Resolved	Muscle weakness	□Ongoing □ Resolved
Sore throat	□Ongoing □ Resolved	Joint/muscle pain	□Ongoing □ Resolved
Sores in mouth	□Ongoing □ Resolved	**Integumentary**	
Dental problems	□Ongoing □ Resolved	Breast pain	□Ongoing □ Resolved
Endocrine		Rash	□Ongoing □ Resolved
Dry skin	□Ongoing □ Resolved	Masses/lumps	□Ongoing □ Resolved
Hot flashes	□Ongoing □ Resolved	Ulcers/open sores	□Ongoing □ Resolved
Abnormal thirst	□Ongoing □ Resolved	Discharge	□Ongoing □ Resolved
Excessive/frequent urination	□Ongoing □ Resolved	**Neurological**	
Hematologic/Lymphatic		Dizziness	□Ongoing □ Resolved
Frequent/severe bruising	□Ongoing □ Resolved	Uncontrolled shaking	□Ongoing □ Resolved
Swollen lymph nodes	□Ongoing □ Resolved	Fainting	□Ongoing □ Resolved
Respiratory		Numbness	□Ongoing □ Resolved
Chronic cough	□Ongoing □ Resolved	Seizures	□Ongoing □ Resolved
Shortness of breath	□Ongoing □ Resolved	Difficulty walking	□Ongoing □ Resolved
Coughing up blood	□Ongoing □ Resolved	**Psychiatric**	
Wheezing	□Ongoing □ Resolved	Depression	□Ongoing □ Resolved
Cardiovascular		Frequent crying	□Ongoing □ Resolved
Painful breathing	□Ongoing □ Resolved	Excessive aggression	□Ongoing □ Resolved
Chest pain/pressure	□Ongoing □ Resolved	Anxiety	□Ongoing □ Resolved
Difficulty breathing on exertion	□Ongoing □ Resolved		
Swelling in legs	□Ongoing □ Resolved		
Heart palpitations	□Ongoing □ Resolved		

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Malnutrition Screening Tool **(MST)**

STEP 1: Screen with the MST

1 Have you recently lost weight without trying?

No	0
Unsure	2

If yes, how much weight have you lost?

2-13 lb 14-23	1
lb 24-33 lb 34	2
lb or more	3
Unsure	4
	2

Weight loss score: _____

2 Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score: _____

Add weight loss and appetite scores

MST SCORE: _____

STEP 2: Score to determine risk

MST = 0 OR 1
NOT AT RISK

Eating well with little or no weight loss

If length of stay exceeds 7 days, then rescreen, repeating weekly as needed.

MST = 2 OR MORE
AT RISK

Eating poorly and/or recent weight loss

Rapidly implement nutrition interventions.

Perform nutrition consult within 24-72 hrs, depending on risk.

STEP 3: Intervene with nutrition for your patients at risk of malnutrition.

Notes: _____

Ferguson, M et al. *Nutrition* 1999 15:458-464

87681-004/February 2014 LITHO IN USA
www.malnutrition.com

AMSN | Academy of Nutrition and Dietetics | slm | Abbott Nutrition

These health organizations are dedicated to the education of effective hospital nutrition practices to help improve patients' medical outcomes and support all clinicians in collaborating on hospital-wide nutrition procedures. The Alliance to Advance Patient Nutrition is made possible with support from Abbott Nutrition.

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PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Patient Name: _____ Date: _____

_____

Are you currently receiving mental health services for a diagnosed condition? Yes/No (Circle one)

If yes, please provide reason for mental health services and where you are being seen: _____

Have you ever been diagnosed with bipolar disorder? Yes/No (Circle one)

If yes, please provide date of diagnosis and no further questions required: _____

If no, please answer the following questions:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things:	0	1	2	3
2. Feeling down, depressed, or hopeless:	0	1	2	3

____0____+_____+_____+_____

= Total Score_____

If the "Total Score" is 3 or greater, a referral to a Licensed Clinical Social Worker will be made for further evaluation. Are you interested in a referral today? Yes/No (Circle One)

CMS eCQM ID CMS2v13 Quality Measure Guideline

TETON CANCER INSTITUTE

Authorization of Medical Records Release of Information Disclosure

Please complete all sections of the form and attach required documentation to ensure timely processing

I,_____*(Patient/Patient Representative)*, authorize **Teton Cancer Institute** to release protected health information (medical records) for the individual named below:

Patient Last Name:_____ **Patient First Name:** _____

Patient Date of Birth:_____ **Phone Number:**_____ **Previous Last Name (if applicable):** _____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

The Purpose of this disclosure is:

☒ Medical Care or Consultation ☐ Billing or Claims Payment ☐ Personal Use ☐ Legal ☐ Other: _____

Date(s) of Service: *from*_____ *thru* _____

Information to be released: *(A copy fee of $1.00 per report will be charged if applicable)*

☒ Lab Reports ☒ Radiology Reports: Disc Images_____Reports _____ ☐ EKG ☒ Operative Reports ☐ Itemized Bills

☒ Chart Notes (Face sheet, History & Physical, Operative Report, Discharge Summary, Consultations, and Discharge Instructions)

☐ Other: _____

I understand that if my medical or billing record contains information in reference to the conditions described below, **I must agree to the release by initialing on each applicable line:**

_____ HIV/AIDS testing or treatment

_____ Psychiatric treatment (excluding psychotherapy notes)

_____ Genetic testing records

_____ Sexually transmitted diseases

_____ Drug or Alcohol Abuse Records (diagnosis, treatment, or referral, excluding counseling notes)

_____ Hepatitis B or C testing

INITIAL:_____ I understand that my records may include **reproductive health** information.

Information to be released to: ☐ Self - same as above information

Name of Third Party Receiving Records: _____

Phone Number:_____ **Fax Number:**_____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

This authorization will expire in one (1) year unless an earlier date is specified: _____

(continued on reverse side)

Patient Sticker

Last_____

First_____

DOB_____

MRN _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.

TETON CANCER INSTITUTE

Authorization of Medical Records Release of Information Disclosure

Please complete all sections of the form and attach required documentation to ensure timely processing

I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

I understand that I may revoke this authorization at any time by giving written notice to the Director of Health Information Management, 2325 Coronado St., Idaho Falls, ID 83404. I understand that revocation will not affect any action **Mountain View and affiliates** took by relying on this authorization before they received my written notice.

I understand that this authorization to use or disclose protected health information is voluntary and **Mountain View Hospital or Teton Cancer Institute** cannot deny or withhold health care services if I do not sign the authorization, except if the authorization is required for a research study in which I am enrolled, or if the service is solely for a third-party (pre-employment physical, etc.).

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, and genetic information.

Signature of Patient_____Date/Time_____

☐ Patient unable to sign ☐ Other Responsible Party _____
(Reason/Description of Authority)

Signature of Authorized Agent_____Relationship_____Date_____

Witness Printed Name:_____ Title: _____

Witness Signature:_____Date:_____Time: _____

For Staff Use

Records to be released via ☐ US Mail ☐ Fax ☐ Personal Pick-up ☐ Emailed Paper Copies (including faxes CD/DVD)

Form of ID or Proof Submitted:

☐ Driver's License
☐ Guardianship/Conservator Orders
☐ Durable Healthcare Power of Attorney
☐ Other:_____

☐ Birth Certificate
☐ Death Certificate
☐ Signature Verification

Patient Identification or Proof of Authority to Authorize Release verified/processed by:

Printed Name:_____Title:_____Date: _____

Patient Sticker
Last_____
First_____
DOB_____
MRN _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.

Continuity of Care Form: Requesting Records to Outside Entities

Please complete all sections of the form and attach required documentation to ensure timely processing

I,_____*(Patient/Patient Representative)*, authorize **Teton Cancer Institute** to request protected health information (medical records) for the individual named below:

Patient Last Name:_____ **Patient First Name:** _____

Patient Date of Birth:_____ **Phone Number:**_____ **Previous Last Name (if applicable):** _____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

The Purpose of this disclosure is:

☒ Medical Care or Consultation (Continuity of Care) ☐ Other: _____

☐ **Date(s) of Service:** *from*_____ *thru* _____

Information to be requested:

☒ Lab Reports ☒ Radiology Reports: Disc Images_____ Reports_____ ☐ EKG ☒ Operative Reports

☒ Chart Notes (Face sheet, History & Physical, Operative Report, Discharge Summary, Consultations, and Discharge Instructions)

☐ Other: _____

I understand that if my medical or billing record contains information in reference to the conditions described below, **I must agree to the request by checking box on each applicable line:**

☐ HIV/AIDS testing or treatment
☐ Psychiatric treatment (excluding psychotherapy notes)
☐ Genetic testing records
☐ Sexually transmitted diseases
☐ Drug or Alcohol Abuse Records (diagnosis, treatment, or referral, excluding counseling notes)
☐ Hepatitis B or C testing

INITIAL:_____ I understand that my records may include **reproductive health** information.

Requested Information to be sent to:

Facility Name: _____

Phone Number:_____ **Fax Number:** _____

Street Address:_____ **City:**_____ **State:**_____ **Zip Code:** _____

(continued on reverse side)

Patient Sticker
Last_____
First_____
DOB_____
MRN _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.

Continuity of Care Form:
Requesting Records to Outside Entities

Please complete all sections of the form and attach required documentation to ensure timely processing

Please send Medical Record information to:

Teton Cancer Institute
An Affiliate of Mountain View Hospital
380 Walker Drive, Rexburg ID 83440
Phone: (208)356-9559
Fax: (208)356-6601

Signature of Patient_____Date/Time_____

☐ Patient unable to sign _____
(Reason)

Signature of Authorized Agent_____Relationship_____Date_____

Staff Printed Name:_____Title: _____

Staff Signature:_____Date:_____Time: _____

PART OF THE MEDICAL RECORD.
SCAN AFTER COMPLETION.

Patient Sticker
Last_____
First_____
DOB_____
MRN _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TETON CANCER INSTITUTE

The Individuals listed in the chart below will be allowed to obtain medical information concerning you, the patient:

NAME	RELATIONSHIP

Signature: _____ Date: _____

Patient, Parent or Legal Guardian

Witness: _____ Date: _____

MVH Employee

IDAHO FALLS COMMUNITY HOSPITAL

Mountain View Hospital

Getting you back to what you Love

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Mountain View Hospital Oncology Services located at Teton Cancer Institute. Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to do better utilize available appointments for our patients in need of medical care.

When you schedule an appointment with Mountain View Hospital or any of its affiliated locations we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and charged a **$25.00 fee.**
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee.**
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Mountain View Hospital.
- Any new patient who fails to show for their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A "no show" is someone who misses an appointment without canceling it within a 24 hour working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

Delays can happen, however, we must try to keep the other patients and doctors on time. If you are running late, please notify the office. If a patient is **15 minutes** past their scheduled time, we may have to reschedule your appointment.

You may contact Mountain View Hospital 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages left at either location are acceptable.

Mountain View Hospital .....(208) 557-2700

Affiliated office: Teton Cancer Institute (208) 523-1100

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Parent/Legal Guardian)	Relationship to Patient
Printed Name	Date

FOR THE BEST CARE, **ENROLL TO SHARE**

How many times have you had to list your allergies, medications and medical history? Wouldn't it be great if all of your doctors had instant and secure access to your medical information? No more carrying health records back and forth. No more recalling what your last lab results or medications prescribed were.

When you enroll in CommonWell Health Alliance® Services, you're enabling your health care providers to access information they may need to care for you.

WHAT ARE THE COMMONWELL SERVICES?

A free, more secure service that makes your health information available to your doctors regardless of where you've received care. Simply enroll in the service with a government-issued photo ID, and then confirm the other CommonWell doctors where you have been seen.

HOW DOES COMMONWELL HELP YOU?

- **Helps your doctors share information** — Allows your different doctors – primary care providers, specialists, hospitals and more – to have more secure, near instant access to your important health information. This includes health facilities you may visit near home as well as while you are traveling in the US.
- **Gets you faster and better care** — With less time wasted on tracking down your test results and other health information, your health care providers can spend less time on paperwork and more time on your care.
- **Supports you in case of emergency** — There may be a time when you don't have the ability to gather or share your health information. Medical staff could immediately pull your allergies, medications and health problems, helping them care for you without delay.
- **Protects your data** — Electronic sharing is more secure than a fax or paper file, which could be easily lost or viewed with no tracking of who accessed that paper record.
- **Reduces paperwork and hassle.** Save time and the hassle of filling out the same health history forms over and over when you see new doctors or go to a specialist in the CommonWell network. Your latest health information will be right at their fingertips.

ENROLL TODAY IT'S EASY!

Just tell the front desk you'd like to enroll in CommonWell Services, and they'll have you verify the other participating health facilities you've visited.

commonwell® HEALTH ALLIANCE

Mountain View Hospital
CLINIC CONDITIONS OF ADMISSION

Patient Name: _____ FIN: _____ DOB: _____
Location: _____ MRN: _____ Date: _____

1) **MEDICAL AND SURGICAL CONSENT:** I, the undersigned, consent to the services which may be performed during this outpatient visit, including office visit, which may include but are not limited to laboratory procedures, radiology procedures, diagnostic procedures, stress testing, medical, nursing or surgical treatment or procedures, anesthesia, pathology, emergency procedures, or hospital services rendered to me under the general and special instructions of my physician. This consent includes testing for blood-borne infectious diseases, including but not limited to Hepatitis, Acquired Immune Deficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), if a provider orders such tests for diagnostic purposes. If the patient takes any medications or other substances without orders from the provider, the patient hereby releases the hospital and provider from liability for any reaction that may occur. In the event of an emergency, **I authorize Mountain View Hospital (MVH) to transfer myself to another health care facility should my provider determine it necessary. In addition, I also consent to the release of my medical records to such facility.**

2) **RELEASE OF INFORMATION:** I authorize the clinic and any physician involved in my care to release medical information and supporting documentation of same as compiled in my medical records during the outpatient visit to any organization which is or may be liable or responsible for payment of charges associated with my care. If my injury is work-related, I authorize the clinic to release any information from my medical records to my employer and/ or its designee. I acknowledge that data from my patient records will be accessible to all health care providers participating in my care or treatment, including but not limited to physicians, nurses and technicians at the hospital, home health agencies, ambulance companies, and such other health care agencies involved in my care. I acknowledge that patient medical records at the clinic are made available through computer networks to hospital personnel, providers involved in my care and their offices.

3) **PATIENT PRIVACY** I have read and/or received the information sheet entitled **"HIPAA NOTICE OF PRIVACY PRACTICES"** available to me at **www.mountainviewhospital.org**

☐ **Acknowledged** I have received and/or had the opportunity to review MVH's "Notice of Privacy Practices" either in electronic or paper form. Any questions that I had were answered.

4) **PATIENT RIGHTS** I understand that MVH has adopted an extensive Patient Rights Policy, which affords patients' rights to respect and foster the patient's dignity, autonomy, positive self-regard, civil rights and involvement in their case. These rights are posted throughout our hospital and clinics, available on our website, or available by asking the admissions desk for the Patient's Rights pamphlet.

5) **WEAPONS/EXPLOSIVES/DRUGS:** I understand and agree that if the hospital at any time believes there may be a weapon, explosive device, or illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the hospital may search my room and my belongings, confiscate any of the above items that are found, and dispose of them as appropriate, including delivery of any item to law enforcement authorities.

6) **FINANCIAL AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS:** In consideration of clinic services rendered, I hereby authorize payment directly to the above named clinic for benefits otherwise payable to me, but not to exceed the clinic's regular charges. In addition, I authorize payment of Medicare/Medicaid/Insurance benefits to any contracted provider; this includes, but is not limited to laboratory procedures, radiology procedures, and anesthesia, pathology, or hospital services rendered to me under the general and special instructions of my provider during this encounter. I understand that I am financially responsible for charges not covered by my plan. In the event that I receive a bill for services covered by my insurance plan, I agree to immediately advise the clinic of my insurance coverage for such charges. In the event that this account is not paid according to the terms of the clinic's credit policy, I agree to pay interest at the rate of 18% APR and/or costs of collection, not to exceed reasonable legal fees and court costs. If my account is assigned to a collection agency for collection and suit is filed to recover payment I agree to pay as a reasonable attorney's fee 33% of the principal and interest on my account balance, or any sums awarded by the court, whichever is greater, I further agree to pay reasonable cost of suit.

7) **MEDICARE PATIENT CERTIFICATION:** I certify that the information given by me in applying for payment under Title XVII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

8) **MOUNTAIN VIEW HOSPITAL IS A PHYSICIAN OWNED HOSPITAL:** Upon request a List of Ownership will be provided to you.

☐ **Acknowledged**

9) **LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIAN:** I understand that all physicians furnishing services to me are independent contractors and are not employees or agents of the hospital. I am under the care and supervision of my attending physician and it is the responsibility of the clinic and its staff to carry out the instructions of my physician. It is my physician's responsibility to obtain my informed consent, when required, for medical or surgical treatment, special diagnostics or therapeutic procedures rendered to me. I understand that the hospital does bill for some professional fees, but some professional fees are not included in the hospital's bill and will be billed separately by the physician/provider.

10) **NOTICE REGARDING PATIENT PROTECTIONS AGAINST SURPRISE BILLING:** Upon request, an information sheet entitled "Your Rights and Protections Against Surprise Medical Bills" will be provided to you. You may also obtain additional information at www.cms.gov/nosurprises.

☐ **Acknowledged**

11) **RIGHT TO RECIEVE A GOOD FAITH ESTIMATE OF EXPECTED CHARGES:** Self pay patients have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services scheduled 3 days or more in advance of a procedure both verbally and in writing prior to service being rendered. You may also obtain additional information at www.cms.gov/nosurprises.

☐ **Acknowledged**

12) **PATIENT RIGHTS:** I have read and/or received the information sheet entitled **"PATIENT RIGHTS"** available to me at **www.mountainviewhospital.org**

☐ **YES** I have received and/or had the opportunity to review Mountain View's "Patient Rights" either in electronic or paper form. Any questions that I had were answered.

☐ **NO** I did not receive nor have had the opportunity to review Mountain View's "Patient Rights".

***13)* USE OF LANGUAGE ASSISTANCE SERVICES.** Mountain View Hospital and affiliated clinics offer language assistance services free of charge to any patients that request aid.

☐ **Acknowledged**

FOR ADMISSION CLERK USE-

☐ Utilized interpreter services to review the COA. ☐ Patient **refused** interpreter services.

***14)* CONSENT TO RECEIVE CONSOLIDATED SUMMARY OF SERVICES AND FINAL STATEMENTS THROUGH ELECTRONIC MEANS.** I hereby agree to receive any Consolidated Summary of Services (CSS) or final statements or any other communication required by the Idaho Patient Act (Idaho Code § 48-301 *et seq.*) ("IPA Communication"), through electronic means by means of the hospital's Patient Portal, which can be accessed from the hospital's website at www.mountainviewhospital.com or directly at www.myhealthcareconnection.org. The Patient Portal can also be accessed via the "My Healthcare Connection" App available on iOS and Android. I understand that it is my responsibility to utilize the Patient Portal for any IPA Communication. I agree that upon upload of any IPA Communications to the Patient Portal, the IPA Communication is deemed to have been received by me for purposes of the Idaho Patient Act. I also understand that in addition to this receipt via the Patient Portal, I can also obtain a copy of any IPA Communication upon request to the Business Office at 208 557-2871.

☐ I certify that I have read (or had read to me) and fully understand the confidential patient terms and understand its contents.

☐ I hereby certify and state that I have read (or had read to me) and that I fully and completely understand the Conditions of Admission and Authorization for Medical Treatment, and that I have signed the Conditions of Admission and Authorization for Medical Treatment knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurance, or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

☐ **Patient is medically unable to sign the Conditionsof Admission** (If marked, provide further details) **- Explanation:**

Signature of Patient _____ Date/Time _____

Patient unable to sign Other Responsible Party _____

Reason:_____

Signature of Authorized Agent _____Relationship_____ Date/Time _____

Name of Staff Witness: _____ Title: _____

Signature of Staff Witness _____ Date/Time: _____