IRONWOOD Family Practice
920 Ironwood Drive, Suite 101 Coeur d'Alene, ID 83814 (208) 667-4557

Please circle name of primary care provider

Timothy F. Burns, MD
David L. Chambers, MD
Donald R. Chisholm, MD
Geoffrey T. Emry, MD
Audrey Buckland, PA-C
Rebecca Jackson, PA-C
Breanna Spencer, ARNP
Jessica B. Capaul, ARNP

PATIENT INFORMATION

Full Legal Name: _____ Previous Last Name: _____
Last First MI

Date of Birth: ____/____/____ Male ____ Female ____ SSN: _____-_____-_____

Marital Status (please circle): Single Married Widowed Divorced

Address: _____
Street or PO Box City State Zip Code

How may we contact you?
Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____**Which phone number is preferred?** Home Cell Work

Pharmacy: _____

Email: _____

EMERGENCY CONTACT

Name: _____ Relationship _____Phone #: (____) _____

Immediate family members who live in your home and who are patients at Ironwood Family Practice:

_____

INSURANCE

Primary Insurance:
Insurance Company Name: _____

ID#: _____ Group #: _____

Subscriber/Employee Name: _____

Sex: _____ DOB: _____ SSN: _____ Relationship to patient: _____

Secondary Insurance:
Insurance Company Name: _____

ID#: _____ Group #: _____

Subscriber/Employee Name: _____

Sex: _____ DOB: _____ SSN: _____ Relationship to patient: _____

GUARANTOR INFORMATION (*person responsible for the bill, if not same as above*)

Full Name: _____ Relationship to Patient: _____
Last First MI

Social Security Number: _____ DOB: _____ Male___ Female___

Mailing Address: _____
Street or PO Box City State Zip Code

Home Phone: (____) _____ Cell Phone: (____) _____

Employer/School: _____ Work Phone: (____) _____

IRONWOOD
Family Practice

FINANCIAL AGREEMENT/RELEASE OF INFORMATION/OFFICE POLICIES

I request that payment of authorized Medicare or other insurance benefits be made to Ironwood Family Practice for any services furnished to me by Ironwood Family Practice. I authorize Ironwood Family Practice to furnish all requested medical information of the persons or entity names above if requested by my insurance company in order to process my claim. I acknowledge that I have reviewed Ironwood Family Practice's financial policy. I understand that regardless of my insurance status, I am solely responsible for payment of any professional services rendered to me, or on my behalf, whether or not paid by my insurance company. I acknowledge I have received and read a copy of the Ironwood Family Practice office policies.

Signature of Patient or Legal Guardian: _____ **Date**: _____

Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Ironwood Family Practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be made available to me upon request.

Signed: _____ **Date:** _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

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AUTHORIZATION FOR IRONWOOD FAMILY PRACTICE TO UTILIZE INFORMATION AS DESCRIBED IN PRIVACY NOTICE

Name of Patient: _____

Please indicate by signature below that you are authorizing us to use private patient information as indicated in our Notice of Privacy Practices. This is not a change in how we have historically used your information. New laws require us to disclose how we use this information.

Signed: _____ **Date:** _____

PATIENT'S CONSENT FOR IRONWOOD FAMILY PRACTICE TO SHARE PROTECTED HEALTH INFORMATION WITH OTHER NAMED PARTIES

In addition to our normal operational disclosures of privacy information, please identify to whom we may release your health care information. Each name must be identified. These should be people who help you with your health care needs and may need to be knowledgeable about your condition, treatment, and options. It is still the responsibility of the below named parties to request this information.

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Signed: _____ **Date:** _____

IRONWOOD
Family Practice

ADDITIONAL DEMOGRAPHIC INFORMATION

Patient Name: _____

In reviewing demographic records, we found that we are missing Race, Ethnicity, and Preferred Language information for our patients. Please help us to gather this information and select the choices that best suit you. IFP greatly appreciates your cooperation.

RACE **(Please circle one of the following):**

Declined
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Other Race_____
Black or African American
Asian
White

ETHNIC GROUP **(Please circle one of the following):**

Declined
Hispanic or Latino
Not Hispanic or Latino

PREFERRED LANGUAGE **(Please circle one of the following):**

English
French
Russian
Other
Arabic
German
Spanish
Chinese
Japanese
Vietnamese

Signature (Patient/Guardian) _____ **Date:** _____

Relationship to Patient: _____

MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Ironwood Family Practice can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to enroll me in the e-Prescribe Program that allows for retrieval of my medication history. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Consent:

_____ _____
Print Patient Name Patient DOB

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

Deny:

_____ _____
Signature Date

Patient Centered Medical Home Agreement

We are pleased to inform our patients that Ironwood Family Practice has received recognition, through standards of the National Committee for Quality Assurance (NCQA), as a Patient Centered Medical Home (PCMH). A **Patient Centered Medical Home** is a team-based approach to your medical care led by your personal physician. As the name implies, you are the most important part of the team, becoming an active participant in your own health and well-being. You share in the responsibility of your care, working together with your "team" to maximize your health outcomes.

This Patient Centered Medical Home agreement details how you and your team will work together to meet your healthcare needs.

Your Healthcare Team's Role:

- Ask about you, your family, your life situation and personal preferences; treatment options and suggestions will be made considering what makes sense for you
- Listen to your questions and concerns
- Respond to questions regarding your health in a timely manner
- Make sure you understand your health situation clearly and are aware of all care options
- Provide you with test results as soon as they are available
- Coordinate your care through additional services and trusted specialists when necessary
- Provide you with information on classes, support groups and other community services to help manage your care outside the practice
- Work with you to create an individualized Care Plan, setting goals for your care and help you to meet those goals

Your Responsibilities as a Patient:

- Keep scheduled appointments or call to reschedule/cancel as soon as possible
- Follow the Care Plan you and your team have agreed upon
- Take medications as directed
- Tell us when you receive care from other healthcare professionals
- Ask questions about your care; tell us when you don't understand something
- Provide a detailed and updated medication list, including Over-The-Counter medications/supplements and herbal remedies
- Provide a complete medical history, including information about immediate family members
- Provide current copies of documents important to your care, e.g. Living Will and Medical Power of Attorney.

Patient Name (Print): _____ DOB: _____

Patient Signature: _____ Date: _____

IRONWOOD
Family Practice

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Full Name of Patient (Please Print):_____

Maiden Name/Alias: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

THE HEALTH CARE INFORMATION THAT I AUTHORIZE TO BE RELEASED IS:

☐ **ALL HEALTH CARE INFORMATION** in the medical record

☐ Health care information in the medical record related to the following treatment or condition:

_____

☐ Health care information in the medical record for the date (s): _____

☐ Other (e.g. x-rays, bills), specify date (s): _____

INCLUDE the following information from the records released (please initial):

Mental Health/Psychotherapy Notes _____ Drug and/or alcohol use_____ Sexually transmitted diseases_____

HIV (AIDS virus) _____ Other _____

This record is requested for the following reason:

☐ Transfer of Care to (Name of Provider):_____

€ Going to Specialist ☐ Insurance Purposes € Personal Interest € Legal Purposes

☐ Other (specify) _____

**** FOR MULTIPLE PROVIDERS/CLINICS, PLEASE LIST ON BACK OF THIS FORM.**

I request and authorize:	**To release my records to:**
Clinic/Provider: _____	Ironwood Family Practice
Address: _____	920 Ironwood Drive, Suite 101
City: _____ State: _____ Zip: _____	Coeur d'Alene, ID 83814
Phone: _____ Fax: _____	Phone (208) 667-4557 Fax (208) 765-2887

I understand that there may be a charge for this service, and I agree to pay said charge on demand.

I understand that the medical record released pursuant to this authorization could contain information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious diseases, which are subject to federal and/or state restrictions on disclosure. If Ironwood Family Practice is asking to use/disclose my information, I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, enrollment in any health plan, or payment/benefit eligibility. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I hereby affirm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above.

SIGNATURE: _____ **DATE:** _____
Patient, Parent, or Legally Authorized Individual

Relationship to the Patient:_____

Social Security Number: _____ Phone Number: _____

Expiration: This authorization expires on this date or event: _____. **I understand this authorization will expire 90 days from the date signed if no specific expiration date is indicated.** The authorization may be revoked by notifying Ironwood Family Practice in writing at any time except to the extent action has been taken prior to revocation.

I request and authorize:
Clinic/Provider/Patient Name: ____________________________________
Address: ____
City: _________________________________ State: _______ Zip: ________
Phone: _______________________________ Fax: _____________________

To release my records to:
Ironwood Family Practice
920 Ironwood Drive, Suite 101
Coeur d'Alene, ID 83814
Phone (208) 667-4557 Fax (208) 765-2887

I request and authorize:
Clinic/Provider/Patient Name: ____________________________________
Address: ____
City: _________________________________ State: _______ Zip: ________
Phone: _______________________________ Fax: ___________________ __

To release my records to:
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I request and authorize:
Clinic/Provider/Patient Name: ____________________________________
Address: ____
City: _________________________________ State: _______ Zip: ________
Phone: _______________________________ Fax: ___________________ __

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I request and authorize:
Clinic/Provider/Patient Name: ____________________________________
Address: ____
City: _________________________________ State: _______ Zip: ________
Phone: _______________________________ Fax: ___________________ __

To release my records to:
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Coeur d'Alene, ID 83814
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I request and authorize:
Clinic/Provider/Patient Name: ____________________________________
Address: ____
City: _________________________________ State: _______ Zip: ________
Phone: _______________________________ Fax: _____________________

To release my records to:
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I request and authorize:
Clinic/Provider/Patient Name: ____________________________________
Address: ____
City: _________________________________ State: _______ Zip: ________
Phone: _______________________________ Fax: ___________________ __

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IRONWOOD Family Practice

Clinical History Form

Date: _____

Patient Name: _____ Date of Birth: _____

Review of Systems

Please circle any of the following you are currently experiencing:

GENERAL	EYES	ENT	CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	GENITOURINARY
Fatigue	Blurred vision	Hearing Problems	Chest Pain/Pressure	Cough—Acute	Abdominal pain	Painful Urination
Fever	Eye Drainage	Ear Ringing	Dizziness	Cough—Chronic	Diarrhea	Blood in Urine
Night Sweats	Eye Pain	Nosebleeds	Palpitations	Shortness of breath	Blood in stool	Frequent Urination
Weight Gain	Light Sensitivity	Hoarseness	Feet Swelling	Blood-Tinged Sputum	Nausea	Incontinence
Weight Loss	Double vision	Sore Throat	Varicose Veins	Wheezing	Vomiting	Flank Pain

MUSCULOSKELETAL	SKIN/BREASTS	NEUROLOGICAL	HEMATOLOGIC/LYMPHATIC	ENDOCRINE	MALE	PSYCHOLOGIC
Joint Pain	Lesions/Moles	Fainting	Easy Bruising	Hair Loss	ED	Depression
Back Pain	Itching	Headaches	Excessive Bleeding	Heat/Cold Intol	Impotence	Anxiety
Joint Stiffness	Rash	Confusion/Memory Loss	Lymph Node Swelling	Excess Thirst		Severe Stress
Extremity Pain	Breast Mass	Numbness/Tingling	Anemia	Excess Sweat		Sleep Disturbance
Muscle Pain	Breast Tenderness	Seizure				

Allergies

€ NONE € MEDICATIONS € LATEX € FOOD € OTHER

List Allergies and Reactions:

_____ _____

_____ _____

Prescription/Non-prescription Medications/Vitamins/Supplements

Medication Dose/Number Per Day	Medication Dose/Number Per Day	Medication Dose/Number Per Day
1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11 _____
4. _____	8. _____	12. _____

Supplements Current Use: Appetite Suppressant "Fat Burners" Multivitamin Creatine Ginseng SAM-e DHEA MaHuang Xenadrine Ephedrine Metabolife Other

Past Medical History

Please check if you have or have had:

€ Arthritis €Asthma €Bleeding Difficulties €Depression €Diabetes Mellitus €Emphysema €Heart Disease
€Hepatitis €High BP €High Cholesterol €HIV €Insomnia €Kidney Disease/Stones
€Migraines €Osteoporosis €Seizure Disorder €STD €Stroke €TB €Thyroid Disease
€ Cancer (Type/Treatment) _____

Past Surgical History

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____

Social History

Occupation: _____ Marital Status: Single Married Separated Divorced Widowed
Number of Children: _____
Hobbies/Recreation _____
Exercise: €None Type of Exercise: _____ Frequency: # days per week _____

Family History

Illness	Which Family Members?	Illness	Which Family Members?
Cancer	_____	Hypertension	_____
Heart Disease	_____	Diabetes	_____
Stroke	_____	Mental Disease	_____
Alcoholism	_____	Glaucoma	_____
Bleeding Disorder	_____	Osteoporosis	_____
Thyroid Disease	_____	Other	_____

Father: Living / Deceased Age ____ Cause of Death _____ Brothers: # Alive ____ # Deceased____ Age____ Cause of Death _____
Mother: Living / Deceased Age ____ Cause of Death _____ Sisters: # Alive ____ # Deceased____ Age____ Cause of Death _____

Tobacco/Alcohol/Caffeine

Tobacco Never smoked _____ Past Smoker: Cigarettes Quit Date _____ # packs/day _____
Cigars Quit Date _____ # packs/day _____
Current Smoker: ____ Every day Smoker ____ Intermittent Smoker # cigarettes/cigars per day _____
Smokeless Tobacco: ____ Current Use # cans/pouches per day _____

Alcohol None _____ Frequency: ____ Rare ____ Social ____ Regular Use ____ Binges
Quantity: # drinks per day _____ # drinks per week _____ # drinks per month _____
Types of alcohol: _____ Previous attempt to quit? _____

Caffeine Coffee Tea Soda # servings per day ____ None ____
Illicit Drug Use: Current Use: ____ No ____ Yes Type: _____
Prior Use: ____ No ____ Yes Type: _____ Quit Date: _____

Prevention

If over age 30, have you had your cholesterol level checked in the past 5 years? € No €Yes
Have you ever had a mammogram? € No €Yes If yes, date of last mammogram: _____ Any abnormalities noted? € No €Yes
Have you ever had a colonoscopy: € No €Yes If yes, date of last colonoscopy: _____
Any abnormalities noted: € No €Yes
Date of last dental exam: _____ eye exam: _____

Immunizations
€ Tetanus/Yr _____ € Influenza/Yr _____ € Pneumonia/Yr _____ €Shingles/Yr _____
€ HPV vaccine: #1 _____ #2 _____ #3 _____ € Other/Yr _____

Gynecologic/Obstetric History

Times Pregnant _____ Problems with pregnancy? _____
Problems with menstrual cycles:
_____ None _____ Irregular frequency/duration _____ Dysmenorrhea _____ Heavy Bleeding _____ Other
Current birth control: _____ Age at onset of periods: _____
Age at onset of menopause: _____
Pap Smears: Never _____ Date of last pap _____ History of abnormal paps? € No €Yes

IRONWOOD Family Practice

920 Ironwood Drive, Suite 101
Coeur d'Alene, ID 83814
P: (208) 667-4557 F: (208) 765-2887
www.ironwoodfamilypractice.com

Patient Portal User Agreement

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT NAME: _____ **PATIENT DOB:** _____

PATIENT EMAIL ADDRESS: _____

Ironwood Family Practice provides this site in partnership with e-MDs®, electronic health record (EHR) software, for the exclusive use of its established patients. The patient portal is designed to enhance patient – physician communications. All users must be established by a previous office visit.

We strive to keep all of the information in your records correct and complete. If you identify any discrepancy in your record, we encourage you to notify us immediately. Additionally, by using the patient portal, the user agrees to provide factual and correct information.

The information on the patient portal is maintained by Ironwood Family Practice at its current physical facility – 920 Ironwood Drive Suite 101, Coeur d'Alene, Idaho 83814.

_____
Initial

THE PATIENT PORTAL PROVIDES THE FOLLOWING SERVICES:

- Medical refill request (must be a medication prescribed by an Ironwood Family Practice provider).
- Communication of laboratory results from staff to patient.
- Review/update patient's medical summary, medication list, treatment history and visitation dates.
- Limited communication regarding ongoing treatment.
- Billing questions
- Referral requests

_____
Initial

PATIENT PORTAL <u>RESTRICTIONS</u>:

- No internet-based triage and treatment request. Diagnosis can only be made and treatment rendered after the patient schedules and sees a medical provider.
- No emergent communications or services. In an emergency call 9-1-1 or for an urgent need call the clinic at (208) 667-4557.
- No communication of sensitive subject matter such as mental health, work excuses, HIV/AIDS, etc.
- **NO REQUEST FOR NARCOTIC/CONTROLLED MEDICATIONS WILL BE ACCEPTED.**
- Do not request a refill for a medication not prescribed by an Ironwood Family Practice medical provider.

Patient Portal User Agreement

It may take 72 hours or 3 business days to receive a response to an email request. If you do not receive a response within 72 hours or 3 business days you should contact the office at (208) 667-4557

The patient portal is provided as a courtesy to our valued patients. While some offices charge for this convenience on an annual basis, we are focused on providing the highest level of service and health care.

_____
Initial

At the discretion of Ironwood Family Practice, if abuse or negligent usage of patient portal is suspected, we reserve the right to terminate patient portal offering, suspend user access, or modify services offered through the patient portal.

PROTECTING YOUR PRIVATE HEALTH INFORMATION AND RISKS

The patient portal is provided in partnership with e-MDs®, our EHR software vendor and provider. The data is stored at Ironwood Family Practice. The data is on HIPAA-compliant VPN with high level encryption that exceeds the HIPAA standards. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. To the extent that it is possible, Ironwood Family Practice has undergone rigorous IT implementation and security standards exceeding industry recommendations.

Please read our HIPAA policy for information on how private health information (PHI) is used at Ironwood Family Practice. All new and established patients have signed a HIPAA agreement form and have been given a copy of our HIPAA policy. If you do not recall having signed a HIPAA agreement form or need to reacquaint with our HIPAA policy, a printed copy will be provided to you for your review.

Ironwood Family Practice will do its best to maintain electronic security. Keeping messages secure depends on two additional factors:

- The secure message must reach the correct email address.
- Only the correct individual (or someone authorized by that individual) must be able to have access to messages.

_____
Initial

You are responsible for ensuring that Ironwood Family Practice has your <u>current email address</u> and you agree to inform us immediately if it changes. You are to protect your username and password information as you would protect your banking information. You are to safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately notify Ironwood Family Practice so this can be changed. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times.

Always remember to log out and close your browser when you are finished accessing password protected patient portal services. This prevents someone else from accessing your personal information. **YOU SHOULD NEVER USE A PUBLIC COMPUTER TO ACCESS THE PATIENT PORTAL.**

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. By signing this consent I understand that patient portal will now be the primary way my provider and my provider's nurse will communicate with me for non-urgent communications and I also understand that it is my responsibility to check my email regularly. I have been given risks and benefits of patient portal and agree that I understand the risks associated with online communications between my physician and patient, and consent to the conditions outlined herein. I agree not to hold Ironwood Family Practice or any of its staff or physicians liable for network or security infractions beyond their control. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Ironwood Family Practice should I decide against using the patient portal. In addition, I agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that my physician may impose for online communications. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered with clarity.

Patient Signature Date

IRONWOOD
Family Practice

INPATIENT HOSPITAL CARE

The physicians at Ironwood Family Practice have been given the opportunity to become part of the teaching faculty for the Family Medicine Residency program here in Coeur d'Alene. We feel it is an honor and a responsibility to help educate the family medicine physicians of the future. We hope that in doing this, some of them may choose to stay and practice medicine here in our community, which will be of benefit to all who live here. If they do stay, we wish for them to be well trained, and so we have chosen to be a part of the faculty that helped to make this happen. Our involvement will be teaching the resident physicians at the hospital. We, the physicians, will rotate one week at a time, taking care of all patients from Ironwood Family Practice that require hospitalization. We will share that responsibility (in a rotating fashion) with the faculty of the Kootenai Health Family Medicine Coeur d'Alene Residency.

What does this mean for you? Your usual care at our clinic will remain unchanged. We will still take care of your needs (whether it is an acute illness, laceration, skin lesions, etc.) or persistent care needs (such as high blood pressure, diabetes, or elevated cholesterol). However, now, when you are ill to the point requiring hospitalization you will be admitted to the family medicine service of which we will be an integral part. There will be a team of physicians who will work together and see you daily making sure you receive excellent medical care while in the hospital. Even when we are not the actual attending physicians overseeing your day-to-day care, we will be made aware of your admission and help in your care by giving additional history and advice about your medical needs. We see this as a positive change, as you, the patient, will receive the most up to date care by a team of physicians while in the hospital (of which we will remain involved). The patients seen at the Ironwood Family Practice clinic will have more concentrated care with less physician interruption from hospital patient needs. The community will benefit from excellently trained family physicians.

Thanks again for allowing us to be a part of your life and helping with your medical needs.

Timothy F. Burns, MD
Donald R. Chisholm, MD
Breanna A. Spencer, ARNP
David L. Chambers, MD
Geoffrey T. Emry, MD
Jessica B. Capaul, ARNP
Rebecca L. Jackson, PA-C
Audrey S. Buckland, PA-C

IRONWOOD
Family Practice

OFFICE POLICIES

OFFICE APPOINTMENTS

Our clinic is open Monday – Friday, 7:00 a.m. to 5:00 p.m. Office visits are by appointment which should be scheduled in advance. Same-day appointments are usually available for urgent or sudden illness. However, we have a limited number of same-day appointments available every day. If there is not an available appointment with your primary care physician, you will be offered an appointment with the on-call physician or one of the midlevel providers.

CANCELLATIONS: If you cannot keep your scheduled appointment, we ask that you notify us as soon as possible. You may be charged a fee if office visits are not cancelled at least 24 hours prior to a missed appointment.

EMERGENCIES/AFTER HOURS: If you have a life-threatening emergency, you should call 911 or go immediately to the nearest emergency room. If you need to see a physician after regular office hours for urgent or emergent problems, you can be seen at the Kootenai Urgent Care, which is a physician-owned urgent care facility located in Coeur d'Alene, Hayden, and Post Falls. Appointments for prescription refills and long-term illnesses should be handled during routine office hours.

WALK-IN VISITS: Walk-in visits should only be used for true emergencies, as they create a scheduling problem for everyone. We ask that you please call first so we can advise you on the best approach to ensure appropriate medical care. In the event you cannot call ahead and your need is urgent, we will have a member of our clinical staff evaluate your needs and you will be seen on a first come, first served basis, depending on the urgency of the situation.

TELEPHONE CALLS

Every phone call is important to us, and we will attempt to answer your calls and return your phone messages as promptly as possible. Please leave a phone number where you know we will be able to reach you. If you call for an urgent matter, we will make every effort to respond immediately.

Please be aware that the providers will not leave their scheduled patients to return routine phone calls; these are generally answered after patient care sessions are finished.

Good medical care cannot always be accomplished over the phone, so we may advise you to schedule an office visit to discuss your concerns, problems, or test results.

PRESCRIPTION REFILL POLICY

If you need a refill on a previously prescribed medication, please contact your pharmacy. The pharmacist will fax us your request along with the current dosages and medications for your healthcare provider's approval. In general, when refills are needed for your prescription, this means it is time for a follow-up appointment with your healthcare provider. For your safety, you may be asked to make an appointment at Ironwood Family Practice before your medications are refilled. **Please remember to allow 2 working days** from the time we receive the fax from the pharmacist for your refill request to be processed.

MAIL-ORDER PHARMACIES: If you choose a mail-order prescription service, your healthcare provider will be happy to fax or e-prescribe prescriptions, refillable 6 months to 1 year. At your request these chronic daily medications will be renewed until you are due for your next appointment. Most medical conditions requiring chronic daily medications need to be reevaluated by your healthcare provider at least every 6 months and appropriate renewal of your mail-order prescriptions can be done at the time of your 6-month follow-up appointment. Additional information, which may have changed since previous refills, is also needed for mail-order prescription services. The accuracy of this information can be checked at the time of your appointment. If you are requesting prescriptions for mail order at other times, you may request through your pharmacy or patient portal. **We will not be responsible for your mail-order pharmacy sending you the wrong prescription. Please remember to allow 2 weeks to receive your medications in the mail.**

MEDICAL RECORDS

Ironwood Family Practice is happy to provide each patient with one complete copy of their chart free of charge. If additional copies of the chart are requested by the patient there will be a charge per page and payment will need to be received before records are released.

Please allow 7 to 10 working days for your medical record release request to be processed. If you have a situation in which you need your copies released sooner, please contact our medical records department at (208) 667-4557 and they will assist you.

It is the responsibility of a patient to arrange for the transfer of medical records from their prior physician to our practice. We are happy to provide you with a Request for Release of Medical Records form to sign and send to your previous physician/healthcare provider.

TREATMENT OF A MINOR

During your absence, your child may suffer an illness or injury that requires medical attention. To ensure that your child will get the necessary attention as timely as possible, you should complete a Consent to Treatment of a Minor form, which is available on our website or at the office. This form gives Ironwood Family Practice permission to treat your child if the need arises.

EMPLOYEE CONFIDENTIALITY STATEMENT

Each employee at Ironwood Family Practice is required to sign a confidentiality statement assuming an obligation to keep in confidence all information that pertains to all patients. It is the expectation of Ironwood Family Practice that every person employed in any capacity in the clinic shares this responsibility. All employees shall avoid discussing a patient or any information about a patient with any person except as required to fulfill a job requirement.

REFERRALS

Some managed care insurance companies require you to obtain a referral authorization before seeking healthcare from another facility. If your insurance company requires a referral authorization and you need to seek care from another facility other than Ironwood Family practice, please make an appointment with your primary care provider to evaluate your needs and determine your best plan of treatment.

If you do not receive a referral from your provider prior to your appointment with a facility outside Ironwood Family Practice, your visit may not be covered by your insurance company. As a patient, it is your responsibility to ensure that the facility you are seeking a referral to is covered on your insurance plan. It is also your responsibility to inform your provider that a referral is required—it is not Ironwood Family Practice's responsibility to know which insurance companies require a referral to a specialist.

Once your provider has requested a referral authorization, our referral coordinator will submit the necessary information to your insurance company. Some insurance companies will send a letter to you and the specialist, authorizing or denying your referral. Depending on your insurance company, a referral can take two to three days to process. If you do not receive notification that your referral has been approved from your insurance company two to three days prior to your appointment, please contact your insurance company for assistance.

Financial Policy

About Us:
Ironwood Family Practice is committed to providing high-quality, comprehensive family health care and personal service to our patients. For every commitment, there is an obligation. It is the patients' responsibility to meet their financial obligations. As we see patients from many different insurance plans, it is impossible for us to be certain of all the covered benefits, copays and deductibles for each individual plan. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered or referred by Ironwood Family Practice on your behalf are paid in full. In order to clarify Ironwood Family Practice's Financial Policy, we have listed below our financial requirements:

Contracted, PPO & HMO with Copays
If we are contracted with your insurance carrier, we will bill your insurance for you. Copays are collected upon check in at the time of service, as required by your insurance company. There may be situations where you may be left with a balance when unknown copays, deductibles or non-covered services exist. This balance is due 30 days from the date on the billing statement you receive. You will not receive a statement of a balance due from our office until after your insurance carrier has processed your claim, either paying their portion of the charges, applying them to your deductible, or transferring them to patient responsibility.

Deductibles
If the patient's insurance has a deductible that must be met before insurance payment will begin, it is expected that patients will pay for their visit in full at the time of their visit. We will continue to bill patient insurance so that deductible credit may be received, however, 10% discount offered to cash patients will not be available. The billing office must be contacted prior to the office visit if short term payment arrangements are needed. Ironwood Family Practice does accept Visa, Mastercard, and Discover as a payment option, but we are unable to extend credit to patients in a long term manner. Please contact the billing office with any questions/issues regarding this request.

Non-Contracted or Other Insurance Carriers
As a courtesy to our patients, we will bill your primary insurance. We do expect payment in full for services rendered within 30 days of your visit.

Patients Without Insurance Coverage
Payment at the time of service is required. We offer a 10% discount to patients paying for their services in full at the time of their visit. Short-term payment plans are available but should be requested prior to the services being performed.

New Patients
If you are a new patient and you have a listed copay, the copay is collected at the time of service. If you do not have a listed copay, you are required to pay $30 at the time of service. If your insurance requires a deductible be met prior to claims being paid by your insurance then we expect payment in full at the time of your visit or short term payment arrangements to be made prior to your visit. If you have a balance after your insurance carrier has processed your claim, you will receive a statement for the remaining balance and payment is expected within 30 days. If you do not have insurance, payment at the time of service is required. The 10% discount, as noted above, will apply.

Medicare Patients
We will bill Medicare for you. You will receive a statement after Medicare has processed your claim, either paying their portion of the charges, applying them to your deductible, or transferring them to the patient responsibility. If you have supplemental insurance to Medicare, we will also bill your Medicare Supplement for you. You will receive a statement from our office after Medicare and your secondary insurance have processed your claim.

Medicaid Patients

We accept children under the age of 18 years old that reside in Kootenai County on the Idaho State Medicaid program. Children on the Medicaid program are required to present a current medical card to the receptionist upon arrival at each visit. If you do not have your current medical card upon arrival and we are unable to verify your eligibility, you may be asked to reschedule your appointment or pay for your services in full at the time of service.

Workers Compensation Claims

If you are seeing one of our providers for an injury that occurred during the course of your employment, please be sure to notify the receptionist or scheduler when making the appointment that this is work-related. In some cases work-related injuries will be referred to Kootenai Urgent Care Occupational Medicine Department for treatment. By advising the office that this is work-related we are then able to determine which location would be the best place for you to receive care. You will be given the proper paperwork to be filed with your employer and their insurance carrier for payment of services. Please be advised that our office is obligated by law to report all work-related injuries to the Department of Labor and Industries. If your employer or their insurance carrier denies your claim, you will be held financially responsible for all charges incurred for services rendered on your behalf.

****If your injury is covered under Washington Labor and Industry, we cannot see you for this injury.**

Civil Suits, Auto, Home or Business Owners Claims

If you are involved in a civil suit, auto, home or business owner's accident and are seeking payment from the responsible party, we expect payment at the time of service. We do not bill the responsible party's insurance or attorney for your services in these situations due to the length of time it takes to settle these claims. We will provide you a copy of your statement so you can bill the responsible party.

Laboratory and Other Ancillary Services

Although Ironwood Family Practice provides many of its services in the office, at times it is necessary to obtain services from an outside laboratory or other ancillary service. You will receive a separate statement of charges for services provided outside our office. An example of these services would include: laboratory charges for special tests ordered, specimen evaluation, radiological services, etc.

Services Provided to Minors

A "Minor" is defined as someone under the age of 18 who is not considered legally emancipated from his or her parent or guardian. We realize that there may be an arrangement regarding who is responsible when paying for medical services provided to a minor. However, it is our policy that the parent or guardian who requests medical care for the minor is the financially responsible party. We are unable to "split" accounts to bill more than one party in the case of shared custody arrangements, and one parent or guardian will receive all billing statements. It is expected that as parents of the minor child you will work together to assure payment on the account in whatever manner has been arranged by the court or yourselves.

Missed or Failed Appointments

We understand that circumstances may arise causing you to cancel or reschedule your appointment. However, please be considerate to our patients that need to be seen sooner by notifying our office at least 24 hours prior to your scheduled appointment time. If multiple appointments are missed or rescheduled at a late notice it may be determined that we need to discontinue the doctor-patient relationship and we will no longer be able to see any members of your family.

Nonsufficient Funds/Collection Accounts

All nonsufficient funds will be subject to a $20 fee. If your account is turned over to collection, you will be sent a termination letter indicating that you will need to seek medical care elsewhere.

Thank you for reviewing this information carefully. If you have any questions or need to establish a payment plan, please contact our Business Office at 208-664-8253 or www.ironwoodfamilypractice.com

Updated 12/18/2013

NOTICE OF PRIVACY PRACTICES

Effective April 2003—Revised July 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

PURPOSE OF THIS NOTICE

Ironwood Family Practice is committed to preserving the privacy and confidentiality of your health information which is created and/or maintained at our clinic. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinic, including any information that we receive from other health care providers or facilities. This Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We will abide by the terms of this Notice, including any future revisions that we may make to the Notice as required or authorized by law. We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, which will identify its effective date, in our clinic and on our website at ironwoodfamilypractice.com.

The privacy practices described in this Notice will be followed by:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic;
2. All employees, students, residents, and other service providers who have access to your health information at our clinic; and,
3. Any member of a volunteer group which is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment, and health care operations, as further described in the Notice.

Uses and Disclosures of Health Information for Treatment, Payment, and Health Care Operations

The following section describes different ways that we may use and disclose your health information for purposes of treatment, payment, and health care operations. We explain each of these purposes below and include examples of the types of uses or disclosures that may be made for each purpose. We have not listed every type of use or disclosure, but the ways in which we use or disclose your information will fall under one of these purposes.

1. **Treatment**. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

   For example, we may order physical therapy services to improve your strength and walking abilities. We will need to talk with the physical therapist so that we can coordinate services and develop a plan of care. We also may need to refer you to another health care provider to receive certain services. We will share information with that health care provider in order to coordinate your care and services.

2. **Payment**. We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.

   For example, we may need to give health information to your health plan in order to obtain prior approval to refer you to a health care specialist, such as a neurologist or orthopedic surgeon, or to perform a diagnostic test such as a magnetic resonance imaging scan (MRI) or a CT scan.

3. **Health Care Operations**. We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you.

   We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Uses and Disclosures of Health Information in Special Situations

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for below.

1. **Appointment Reminders**. We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.

2. **Treatment Alternatives & Health-Related Products and Services**. We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health-related products or services that may be of interest to you. For example, if you are diagnosed with a diabetic condition, we may contact you to inform you of a diabetic instruction class that we offer at our clinic.

1. **Family Members and Friends**. We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room.

   We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interest to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We also may share your health information with a family member or friend who calls us to request a prescription refill for you.

Other Permitted or Required Uses and Disclosures of Health Information

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission. These instances are as follows:

1. **As required by law**. We may disclose your health information when required by federal, state, or local laws to do so. For example, we are required by the Department of Health and Human Services (HHS) to disclose your health information in order to allow HHS to evaluate whether we are in compliance with the federal privacy regulations.

2. **Public Health Activities**. We may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury or disability; to report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.

3. **Health Oversight Activities**. We may disclose your health information to a health oversight agency that is authorized by law to conduct health oversight activities, including audits, investigations, inspections, or licensure and certification surveys. These activities are necessary for the government to monitor the persons or organizations that provide health care to individuals and to ensure compliance with applicable state and federal laws and regulations.

4. **Judicial or Administrative Proceedings**. We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, but only if efforts have been made to (i) notify you of the request for disclosure or (ii) obtain an order protecting your health information.

5. **Worker's Compensation**. We may disclose your health information to worker's compensation programs when your health condition arises out of a work-related illness or injury.

6. **Law Enforcement Official**. We may disclose your health information in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons, or similar process.

7. **Coroners, Medical Examiners, or Funeral Directors**. We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We also may disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.

8. **Organ Procurement Organizations or Tissue Banks**. If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.

9. **Research**. We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purposes until the particular research project for which your health information may be used or disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients with specific health care needs who may qualify to participate in the research project. Any use or disclosure of your health information which is done for the purpose of identifying qualified participants will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.

10. **To Avert a Serious Threat to Health or Safety**. We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.

11. **Military and Veterans**. If you are a member of the armed forces, we may use or disclose your health information as required by military command authorities.

12. **National Security and Intelligence Activities**. We may use or disclose your health information to authorized federal officials for purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.

13. **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you and another person; or (iii) for the safety and security of the correctional institution.

IDAHO HEALTH DATA EXCHANGE

This office has chosen to participate in the Idaho Health Data Exchange (IHDE). This is a secure statewide internet-based health information exchange, with the goal of improving the quality and coordination of health care in Idaho. If you do not want to participate in the IHDE and you do not want your healthcare information shared with other medical providers involved in your care, you can opt out of participation. To opt out, you must complete and sign the IHDE "Request to Restrict Disclosure of Information" form (form is available at our front desk) and mail or fax it to IHDE. You will receive a letter of confirmation upon completion of your request. This will restrict your information from being released through the exchange only (you will need to directly contact any facility you wish to also restrict your information with). If you do not complete this form, we may share your protected health information with other participating healthcare providers involved in your care through the IHDE.

Uses and Disclosures Pursuant to Your Written Authorization

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information. You may exercise each of these rights, in writing, by providing us with a completed form that you can obtain from medical records department. In some instances, we may charge you for the cost(s) associated with providing you with the requested information. Additional information regarding how to exercise your rights, and the associated costs, can be obtained from the receptionist.

1. **You have the right to inspect and copy your protected health information (fees may apply) –** Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

2. **You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

3. **You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

4. **You have the right to request an amendment to your protected health information –** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. **You have the right to receive an accounting of certain disclosures –** You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

6. **You have the right to receive notice of a breach** – We will notify you if your unsecured protected health information has been breached.

7. **You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

Questions or Complaints

If you have any questions regarding this Notice or wish to receive additional information about our privacy practices, please contact our Privacy Officer, Kelly Lewis, at (208) 667-4557 or kellyl@ironwoodfp.com. If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with our clinic, contact our Privacy Officer at Ironwood Family Practice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.