Teton Medical Group Patient Information

Patient Name: _____ Marital Status _____Gender: _____ Race: _____ SSN:_____

DOB : _____ Age: _____ Home Ph#_____ Cell# _____Email_____

Do you have voicemail? _____ May we leave messages for you if no name is given on your voicemail announcement? _____

Mailing Address_____ Physical Address_____

Parent/Spouse Name_____ Parent/Spouse Ph#_____

Primary Insurance _____Effective Date _____ Policy/ID #_____Group#_____

Policyholder Name: _____ Relationship _____ DOB _____

2nd Insurance _____ Effective Date _____ Policy/ID# _____ Group #_____

Policyholder Name_____ Relationship_____ DOB_____

Policyholder Employer_____ Employer phone#_____

Emergency Contact 1_____

Name Relationship Address Phone

Emergency Contact 2_____

Name Relationship Address Phone

Person responsible for account_____ DOB_____Address_____

Relationship _____Employer _____Home Ph# _____Work Ph#_____

I hereby authorize and request Teton Medical Group and any other healthcare professionals involved in my care (to include Madisonhealth staff acting on Teton Medical Group provider orders) to provide me with all necessary evaluations, therapies, and/or treatments. **Initials_____**

I hereby authorize Teton Medical Group and any healthcare professional working on their behalf (to include Madisonhealth staff) to release any information acquired during my examination or treatment to any physician, hospital, or medical care facility for the purpose of continuation of my medical care. I also consent for my patient data to be exchanged electronically via Teton Medical Group's Interoperability Hub. In addition, I authorize Teton Medical Group to release any information to my insurance company needed to process my claim(s). **Initials_____**

I assign and authorize payment of insurance benefits directly to Teton Medical Group. I understand I will be financially responsible for all services. I agree to pay all deductibles, co-pays, co-insurances, non covered services, and any other charges denied by my insurance company. I understand that Teton Medical Group files my claim as a courtesy and that in no way releases me from being responsible for payment. Payment for patient responsibility amounts is due at the time services are rendered. **Initials_____**

I understand that any laboratory/radiology services provided at Teton Medical Group will be billed directly to me by Madisonhealth. Any billing questions for services provided by Madisonhealth must be directed to Madisonhealth's billing department at (208) 359-6700. **Initials_____**

I understand there will be a returned check fee of **$35.00**, as well as any fees assigned by my financial institution and any fees incurred for collection of any amount returned by my financial institution. **Initials____**

I hereby agree to pay a finance charge of 1.5% per month (18% per annum) on any unpaid patient balances, beginning 60 days after the balance becomes patient responsibility. I authorize Teton Medical Group to report delinquency to a third-party agency for collection which may result in damaged credit, court costs, attorney fees, or garnished wages. I understand that if my unpaid balance is turned to a third-party collection service, I will be responsible for all fees associated with that service. **Initials _____**

I understand that there will be a **$15.00** per appointment fee for each "no show" appointment on my account which will be payable by me before any further appointments may be scheduled. **Initials_____**

I give my consent to have any monthly statements on my account emailed and/or texted to me. **Initials_____**

Teton Medical Group participates in the ID State Board of Pharmacy's prescription drug monitoring program. I give my consent to Teton Medical Group to search and confirm my prescription medication history to reconcile and verify my medications as needed for my care. **Initials_____**

I have read, understand, and agree to the terms in the above said policies.

Signature of Patient or Patient Representative _____ **Date**_____

Medicare/Medicaid Signature Authorization

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to me or to Teton Medical Group and any other healthcare professionals involved in my care (such as Madisonhealth). I also release any information needed from any source to the Health Care Financing Administration in order to determine correct benefits payable.

Signature_____ **Date**_____

PLEASE REVIEW BOTH SIDES OF THIS PAGE