WOODLANDS
FAMILY MEDICINE
30544 HWY 200 – SUITE 301, PONDERAY, ID 83852 • PHONE: 208-263-6300 • FAX: 208-263-6355

Thank you for choosing Woodlands Family Medicine. Our doctors, nurses, and staff are here to provide you with guidance for wellness and help in illness. Following these guidelines helps us serve all our patients better, safer and in a timely fashion.

APPOINTMENTS: 7:30 AM - 4:30 PM

Our clinic operates on an appointment basis, but if you have a sudden illness or injury, we're still going to make every effort to get you in the same day - even if it's with a different doctor.

Cancelling Appointments:

Call promptly (24 hours in advance) if you need to cancel an appointment so that someone else can be seen in your place.

Missed appointments:

If you are not on time for your appointment, it may need to be rescheduled. Cancellations without 24 hour's notice or just not showing up for your appointment will result in a $50.00 no-show fee. Insurance companies do not cover these fees. Multiple missed appointments will result in dismissal from our clinic.

What to bring to every appointment:

- Current insurance card
- Current list of medications (or medications in their labeled bottles)
- Photo ID (driver's license, government issued ID)
- Credit card, Cash, or Check for your Co-Pay

INSURANCE AND PAYMENTS

We are a Preferred Provider for many insurance plans, however, each insurance plan is different, and your plan might not cover your appointment. Only your insurance company can tell you what portion they will pay.

- Cash pay and co-pays are due at the time of service. Ask for a 20% cash discount when paid in full at the time of service.
- If you do not have insurance, you will be required to pay a $170 deposit upon arrival. The balance of your visit will be either refunded or invoiced to you.
- All remaining balances and co-pays are due within 30 days of the statement date. Please contact the billing department if you need to make other arrangements.
- A credit balance of $20 or less will be applied to your future balance unless you request a refund.

PRESCRIPTONS

We refill prescriptions on weekdays only.

Call your pharmacy to start the medication refill process. If a Woodlands provider did not initially prescribe your medication, you may be required to schedule a visit with us to obtain a refill. Pain contract medications will only be filled by YOUR pain-contract provider.

DOCUMENTS AND FORMS - Certain forms (e.g., AFLAC, FMLA, Life Insurance) require additional time or costs. There is a $25 administrative charge for completion of these forms.

Patient Name _____ Signature _____

WOODLANDS
FAMILY MEDICINE

Authorization to Disclose Protected Health Information

RELEASE MEDICAL RECORDS **FROM**:

Office Name: _____

Address: _____

_____

_____

Phone: (_____) _____

Fax: (_____) _____

MAIL or FAX MEDICAL RECORDS **TO**:

Woodlands Family Medicine
30544 Hwy 200, Ste 301
Ponderay, ID 83852

Phone: 208-263-6300
Fax: 208-263-6355

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

Release: ☐ All Dates of Service **OR** ____/____/____ to ____/____/_____

Release: ☐ My complete health record **OR** (Other): _____

Purpose of disclosure: At the request of the individual, for medical care.

This authorization will not expire until revoked in writing **OR on** (Date) : _____/____/_____.

I understand that: I have a right to revoke this authorization at any time. I must make the request in writing and present my written revocation to the provider(s) of care; the revocation will not apply to information that has already been released in response to this authorization; the revocation will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim.

Any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Woodlands Family Medicine is an Assumed Business Name (DBA) under the parent company, 'Michael R. DiBenedetto, MD, PLLC'. All insurance is billed through the parent company. I authorize my healthcare provider to disclose my protected health information to the parent company, Michael R. DiBenedetto, MD, PLLC.

_____ _____ _____

Patient or Authorized Signature | Relationship | Date

Demographic and Insurance Information

Patient Name: _____ DOB: ____/____/____ ☐ Male ☐ Female

Mailing Address: _____

Primary Phone: _____ Employer: _____

Other Phone: _____ Work phone: _____

Email: _____ Social Security Number: ____-____-____
(We will not share this or send spam)

Notify in emergency: _____ Emergency phone: _____

A GUARANTOR IS THE PERSON RESPONSIBLE FOR THE ACCOUNT. THIS COULD BE THE PATIENT, OR SOMEONE ELSE LIKE A PARENT OR GUARDIAN.

☐ THE PATIENT IS THE GUARANTOR (SKIP TO THE NEXT SECTION).

Guarantor Name: _____

Guarantor's DOB: _____ Social Security Number: ____-____-____

Mailing Address: _____

Primary Phone: _____ Employer: _____

Other Phone: _____ Work phone: _____

PRIMARY INSURANCE

Insurance company: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Relationship to patient: _____

Policy #: _____ Group #: _____

SECONDARY INSURANCE

Insurance company: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Relationship to patient: _____

Policy #: _____ Group #: _____

WE ONLY SHARE YOUR MEDICAL INFORMATION AS REQUIRED OR ALLOWED BY LAW. TYPICALLY, WE CAN'T RELEASE INFORMATION TO YOUR SPOUSE OR CHILDREN WITHOUT PERMISSION. FOR EMERGENCY PURPOSES, PLEASE LIST ANY FAMILY OR FRIENDS YOU WOULD WISH TO HAVE ACCESS TO YOUR HEALTH INFORMATION.

Name: _____ Phone Number: _____ Relation: _____

Name: _____ Phone Number: _____ Relation: _____

Name: _____ Phone Number: _____ Relation: _____

_____ _____ _____

Patient or Authorized Signature Relationship Date

WOODLANDS
FAMILY MEDICINE
30544 HWY 200 – SUITE 301, PONDERAY, ID 83852 • PHONE: 208-263-6300 • FAX: 208-263-6355

Insurance and Payments

Payment for services remains the patient's (or guarantor's) responsibility, even if you have insurance. We can almost always submit our claims directly to your insurance company, to assist you in receiving the benefits you are entitled to.

What can YOU do to make sure your insurance pays for your services?

- ✓ Keep your insurance information updated at every doctor's office. Bring us your card if it changes. Insurance companies seem to enjoy denying claims, and a favorite denial is an expired plan.

- ✓ Know your insurance. It is not possible for us to keep track of all the individual requirements of each plan as they are different between individuals and they change frequently. Each plan has different restrictions regarding how often services may be rendered and more importantly, where you should obtain these services. If we perform a service that is not covered by your plan, we will bill you directly for those charges. Because of this, it is ultimately your responsibility to check with your insurance to understand the contract and coverage. You should do this especially if you are scheduling tests or surgery.

Woodlands Family Medicine contracts/participates with the following insurance payers:

Blue Cross	**Idaho Physicians Network**	**North Idaho Health Network**
First Choice Health Network	**Medicaid**	**PacificSource**
First Health	**Medicare**	**Regence***

We do NOT contract with Humana or Regence *Neighborhood plans

We can submit a claim directly to your insurance company for the plans we participate in.

If the claim (or a portion of the claim) is denied, the patient remains responsible for full payment. All patient balances are due within 30 days of the statement date, so you should contact the billing department if you need to make payment arrangements. If payment arrangements are not made and kept, we will utilize the services of a collection agency. The patient is responsible for fees associated with collection services.

I authorize all payments to be sent directly to Woodlands Family Medicine for all amounts due for medical and/or surgical services rendered, including benefit payments from insurance companies or in the event of a settlement. I authorize Woodlands Family Medicine to release any medical information necessary to my insurance company, collection company, and to any specialist and/or referring provider as necessary.

I have read and understand my responsibilities regarding my insurance and agree to accept responsibility as described.

Patient or Authorized Signature	Relationship	Date

Michael R. DiBenedetto, MD, PLLC
30544 Highway 200, Ponderay, ID 83852
208-265-9817

Notice of Privacy Practices and Patient Consent for the Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Michael R. DiBenedetto, MD, PLLC (DBA North Idaho Orthopedics and Sports Medicine; DBA Woodlands Family Medicine), the "corporation," may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Michael R. DiBenedetto, MD, PLLC (DBA North Idaho Orthopedics and Sports Medicine; DBA Woodlands Family Medicine) has a detailed document called the 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. There are copies available in the lobby and on our websites. If I ask, I will be given the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Michael R. DiBenedetto, MD, PLLC (DBA North Idaho Orthopedics and Sports Medicine; DBA Woodlands Family Medicine) to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that the corporation has taken action relying on this consent.

_____ _____
Signature Date

_____
Patient's Name

_____
Relationship if signed by another party

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting us in writing or by phone or on our website at www.woodlandsfamilymed.com or www.niosm.com.

WOODLANDS
FAMILY MEDICINE
30544 HWY 200 – SUITE 301, PONDERAY, ID 83852 • PHONE: 208-263-6300 • FAX: 208-263-6355

Patient name: _____

Where did you hear about us? _____

Previous Doctor: _____

Preferred pharmacy: _____

Other providers currently involved in your care:

_____

_____

_____

Current Medication List (include herbals, vitamins and over the counter medicines:

☐ **None**

Name	Dose	Frequency

Allergies - are you allergic or intolerant to any medication?

☐ **None**

Allergy / Intolerance	Describe reaction

HEALTH HISTORY INTAKE FORM

Name: _____

Past Medical History: (Please check all that apply to you:)

☐ None

☐ Severe Headaches
☐ Stroke
☐ Pneumonia
☐ Diabetes: □Type 1 or □Type 2
☐ Thyroid Disease (Low or High)
☐ Glaucoma
☐ Macular Degeneration
☐ Hearing Loss
☐ Blood clots (legs, lungs, etc.)
☐ Frequent/Severe Reflux/Heartburn
☐ Stomach Ulcers
☐ Incontinence

☐ Kidney Stones
☐ COPD (Emphysema, Bronchitis)
☐ Asthma
☐ Depression
☐ Bipolar disorder
☐ Anxiety
☐ Fibromyalgia
☐ Chronic Fatigue Syndrome
☐ Arthritis
☐ Gout
☐ Osteoporosis
☐ Prostate Disease
☐ Erectile Dysfunction

☐ Breast Disease
☐ Urinary Tract Infections
☐ Cancer: _____

☐ HIV / AIDS
☐ Hepatitis (A, B, C)
☐ High Cholesterol
☐ Heart Disease
☐ Coronary Disease
☐ Heart Attack (MI)
☐ Atrial Fibrillation
☐ Angina
☐ Heart Valve Disorder
☐ Hypertension

Other : _____

Past Surgical History (indicate date if known)

☐ NONE

☐ Cataracts
☐ LASIK
☐ Tonsillectomy
☐ Thyroidectomy
☐ Adenoidectomy
☐ Coronary Bypass
☐ Cardiac Stents
☐ Pacemaker
☐ Heart Valve

☐ Appendectomy
☐ Bowel/Stomach Resection
☐ Hemorrhoidectomy
☐ Hysterectomy:
☐ Abdominal or ☐ Vaginal
Both ovaries intact? ☐ Yes ☐ No
☐ Tubal Ligation
☐ C-Section
☐ Bladder Surgery
☐ Gall Bladder

☐ Prostate Surgery
☐ Endoscopy or EGD
☐ Hernia
☐ Vasectomy
☐ Bariatric
☐ Spinal
☐ Joint Surgery
☐ Orthopedic Surgery
☐ Breast Surgery

Other : _____

Immunizations:

Last Tetanus shot: _____ Did it contain Pertussis (TD or TDaP?) _____
☐ Yes ☐ No Do you receive an annual flu vaccine?
☐ Yes ☐ No Have you had a pneumococcal vaccine (Pneumovax / Prevnar)?
☐ Yes ☐ No Have you had a Tuberculosis (TB) skin test (PPD or Tine)? _____/_____ ☐ Positive ☐ Negative
☐ Yes ☐ No Have you had the Shingrix series? Date: _____

Social:
Occupation: _____ Schooling: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Who lives in the home with you: _____

_____

Diagnostic Studies: **Name:** _____

Test	Date or Year	Comments
EKG/ECG(Electrocardiogram)	_____	_____
Treadmill or Exercise Stress Test	_____	_____
Bone Densitometry	_____	_____
Colonoscopy or EGD	_____	_____
PSA (Prostate)	_____	☐ Positive ☐ Negative

Family Medical History: *If applicable*, indicate medical conditions and age and cause of death including cancers diabetes, heart attack, stroke, high blood pressure, alcoholism or substance abuse, depression or other mental disorders.

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Aunts/Uncles, Children: _____

Females only:

Age at first menstrual period: _____

Age at last menstrual period: _____

Number of pregnancies: _____

Date of last Pap test: _____ Any abnormalities? ☐ Yes ☐ No

Date of last Mammogram: _____

Date of last DEXA Scan _____

Estrogen or female hormones in the last 10 years? From Date:_____ To Date: _____

Social Habits:

How many drinks: _____ daily/weekly/monthly/yearly (circle one)

In the last 3 months have you consumed more than 3 drinks in one sitting? ☐ Yes ☐ No

Are you or others close to you concerned about your alcohol consumption? ☐ Yes ☐ No

Do you live with someone who has an alcohol problem? ☐ Yes ☐ No

Tobacco Use: ☐ Smoke ☐ Chew? Amount of daily use: _____

Former user? ☐ Yes ☐ No # packs per day_____ When did you quit? _____

Caffeine Use: ☐ Yes ☐ No How much per day? _____

Recreational Drugs (including pot): ☐ Yes ☐ No

Your exercise plan: _____

Today's date: _____ Age: _____ Name: _____

Review of Systems

For each section, circle any problems, issues, concerns. I have:

General: Weight loss, Weight gain, Fatigue, Weakness, Fever, Chills, Trouble sleeping, Night sweats

Skin: Rashes, Lumps, Itching, Dryness, Color changes, Hair changes, Nail changes

Head: Headache, Head injury

Eyes: Last exam date: _____
Glasses, Contacts, Vision problems, Blurred vision, double vision, Flashing lights, Specks, Redness, Pain

Ears: Decreased hearing, Earache, Ringing in ears, Drainage

Nose: Stuffiness, Itching, Nosebleeds, Discharge, Hay fever, Sinus pain

Throat/Mouth: Last dental exam: _____
Tooth issues, Gums, Bleeding, Sore tongue, Dry mouth, Sore throat, Hoarseness, Thrush Non-healing sores, Dentures

Neck: Lumps, Stiffness, Pain, Swollen glands

Breast/Chest: Lumps, Pain, Discharge, Breast feeding

Respiratory: Cough, Wheezing, Painful breathing, Shortness of breath, Coughing up blood

Cardiovascular: Chest pain/discomfort, Tightness, Palpitations, Swelling (edema), Difficulty breathing during activity, Difficulty breathing when lying down

Gastrointestinal: Swallowing difficulties, Change in bowel habits , Yellow eyes or skin, Nausea, Heartburn, Constipation, Rectal bleeding, Diarrhea, Change in appetite,

Urinary: Frequency, Urgency, Blood in urine, Change in flow, Incontinence, Burning/Pain

Genitalia – Male: Pain with sex, Sores, STDs, Penile Discharge, Erectile dysfunction, Hernia, Masses, Pain, Frequent urination especially at night

Genitalia – Female: Pain with sex, STDs, Hot flashes, Heavy menses, Itching or rash, Vaginal discharge, Prolonged bleeding, Vaginal dryness, Severe cramps

Vascular: Calf pain with walking, Leg cramping, Swelling

Musculoskeletal: Muscle or joint pain, Back pain, Swelling of joints, Stiffness, Redness of joints, Trauma

Neurological: Dizziness, Weakness, Tremors, Fainting, Numbness, Seizures, Tingling

Hematologic: Bruise easily, Bleed easily (or hard to stop)

Endocrine: Heat/cold intolerance, Frequent Urination, Change in appetite, Thirst, Sweating

Psychiatric: Nervousness, Memory loss, Stress, Depression