GRAND PEAKS
MEDICAL • PHARMACY
DENTAL • BEHAVIORAL HEALTH

PATIENT REGISTRATION

*Today's Date:*_____

PATIENT INFORMATION

Last Name	*First Name*	*Middle Initial*	*Preferred Name*	*Previous Name(s)*
Mailing Address *(Address/P.O. Box, City, State, and Zip code)*				
Home Ph#	*Cell Ph#*		*Work Ph#*	
Date of Birth	*Social Sec #*		*Gender at Birth* ❑ Male ❑ Female	

Gender Identity ❑ Male ❑ Female ❑ Choose not to disclose ❑ Transgender Male/ Female to Male ❑ Transgender Female/ Male to Female ❑ Other

Sexual Orientation ❑ Choose not to disclose ❑ Straight ❑ Bisexual ❑ Lesbian or Gay ❑ Something else ❑ Don't know

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Legally Sep. ❑ Widowed ❑ Partner

Employed? ❑ Yes ❑ No **If Yes:* ❑ PT ❑ FT *Self Employed?* ❑ Yes ❑ No *Student?* ❑ Yes ❑ No *If Yes:* ❑ PT ❑ FT

Employer	*Ph#*	Employed ❑ PT ❑ FT
Emergency Contact *(Name of local relative or friend)*	*Relationship to pt*	*Ph#*
Additional Contacts *(Spouse, Parent, etc. You may list more than one.)*	*Relationship to pt*	*Ph#*

Email Address (Preferably not a work email)

Race ❑ White ❑ Asian ❑ Black/African American ❑ Pacific Islander ❑ American Indian ❑ Alaskan Native

Ethnicity ❑ Not Hispanic/Latino ❑ Hispanic/Latino

Primary Language Spoken ❑ English ❑ Spanish ❑ Other

Interpreter services needed ❑ Yes ❑ No

Are you a Veteran ❑ Yes ❑No

Do you live in public Housing? ❑ Yes ❑ No

Are you Homeless ❑ Yes ❑ No **If Yes, mark one:* ❑ Doubling Up ❑ Street ❑ Homeless Shelter ❑ Transitional ❑ Other

Are you a Migrant worker? ❑ Yes ❑ No *Are you a Seasonal Worker*? ❑ Yes ❑ No

Preferred Communication ❑ Phone ❑ Text ❑ E-Mail ❑ Patient portal ❑ Mail

How did you hear about us (Friend, Advertisement, Facebook, Radio, etc.)

Preferred Pharmacy (Name, Location, Ph # if known)

Full Names of other immediate family members seen here

BILLING / INSURANCE

Guarantor (Person financially responsible for the bill) ❑ Patient is the guarantor/financially responsible, skip to insurance

Full Name (First, Middle Initial, Last) *Ph#* *Date of Birth* *SS#* *Relationship to pt*

Mailing Address (Address/P.O. Box, City, State, and Zip code)
❑ Same as patient

Do you have insurance? ❑ Yes ❑ No **If Yes, we require a copy of the card. Complete the following in order to correctly bill your insurance.*

1. Primary Insurance Co. Name/Address *Policy#* *Group#* *Co-Pay*

Policy Holder Information: *Policy Holder's Name* *(If not patient or guarantor)*
❑ Same as patient ❑ Same as guarantor

Policy Holder's Address *Policy Holder Ph#* *Relationship to pt* *DOB* *Policy Holder SS#*

2. Secondary Insurance Co. Name/Address *Policy#* *Group#* *Co-Pay*

Policy Holder Information: *Policy Holder's Name* *(If not patient or guarantor)*
❑ Same as patient ❑ Same as guarantor

Policy Holder's Address *Policy Holder Ph#* *Relationship to pt* *DOB* *Policy Holder SS#*

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. If I have insurance coverage, I authorize my insurance benefits to be paid directly to the Provider/Upper Valley Community Health Services DBA Grand Peaks. I also authorize Grand Peaks or my insurance company to release any information required to process my claims.

_____ _____ _____

Patient/Authorized Representative Signature Printed Name Date

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APPLICATION FOR SLIDING FEE SCALE / DISCOUNTED SERVICES

*Today's Date:*_____

We offer a Sliding Fee Scale and Discount programs to our patients. These programs can reduce your cost for services in Medical, Dental, Behavioral Health, as well as our Pharmacy! Even if you have insurance, your household may qualify for discounts!

MEDICAL, DENTAL & BEHAVIORAL HEALTH DISCOUNTS	PHARMACY DISCOUNTS
✓ ***Discounts are based upon patient household size & income***	✓ ***All patients are eligible for discounts, regardless of income***
✓ ***Calculation is based on federal guidelines***	✓ ***You must provide proof of income***

TO QUALIFY FOR DISCOUNTS

1. Apply by completing this form (Medicaid patients must complete this form!)
2. Provide proof of income (copies) within 3 business weekdays. All income is kept strictly confidential.
   *Note: We DO require proof of income for Medicare participants.

1. COMPLETE THE FOLLOWING TO DETERMINE ELIGIBILITY:

HOUSEHOLD MEMBERS' NAME(S)	DATE OF BIRTH	WEEKLY INCOME	MONTHLY INCOME	ANNUAL INCOME
Self:				
Spouse/Partner:				
Child:				
Child:				
Child:				
Child:				
Child:				
Child:				
Total calculated Annual Income:				

Total number of family members living in your household (Working and Non-Working):

2. PROVIDE PROOF OF HOUSEHOLD INCOME:

Grand Peaks requires proof of gross income for all family members living in the household. This information must be returned within ***3 BUSINESS WEEKDAYS*** after the date of this application. *Note: Gross income is all income before taxes are with-held.

To verify your income, we are required to have a copy on file of:

- Most recent Federal Tax Return showing annual income (Form 1040)
- **OR** 2 pay-stubs from those working in the household or Disability/Social Security payment statements
- **OR** a letter from your employer stating your wages (or a completed *Employment Verification Form*)
- **OR** a signed letter from someone (not a family member) stating your living situation/income

PLEASE READ CAREFULLY AND SIGN BELOW:

I understand the following:

- If your application is accepted, it will be valid for ONE year.
- I must re-apply annually and provide documentation in order to continue to receive discounted services
- A payment is due and will be asked for/collected at the time of service

To the best of my knowledge, the above information is true and correct. I agree to inform Grand Peaks Medical, Dental, Behavioral Health & Pharmacy of any changes in my household size, employment or financial status. If the above information proves to be incorrect, the discount will be terminated. All information is kept strictly confidential.

_____

Signature Patient/Authorized Representative *Printed Name* *Date*

*IF YOU DO NOT WISH TO PROVIDE INCOME INFORMATION OR RECEIVE ANY DISCOUNTED SERVICES, PLEASE SIGN:

At this time, I DO NOT wish to provide Grand Peaks Medical, Dental, Behavioral Health and Pharmacy with my income information. I understand I will be charged full fees for all services, including pharmacy/prescriptions, for each visit.

_____ _____

Signature of Applicant *Date*

ELIGIBILITY DETERMINATION: ❑Min ❑A ❑B ❑C ❑D ❑E ❑GP Employee Staff initials:_____ Rev 10/2020

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES
CONSENT TO TREATMENT & ELECTRONIC COMMUNICATIONS

HOUSEHOLD MEMBERS (Please list all household members, as well as their date of birth (DOB)			
Patient Name	***DOB***	***Patient Name***	***DOB***

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been provided the *Grand Peaks Notice of Privacy Practices (i.e. the "Notice")*. The "Notice" informs me of how Grand Peaks facilities will use my health information for:

- Purposes of my treatment, payment for my treatment and health care operations.
- Reasons other than treatment, payment and health care operations.
- Use and share health information as required/permitted by law.

I have been provided the opportunity to ask questions and understand I may request and review the "Notice" at any time. I understand this agreement will remain in effect until revoked from me in writing.

I authorize Grand Peaks Medical and Dental to release health information to the following:		
Individual's Name/Facility Name:	Relationship	Phone #(s)/Fax #:
1.		
2.		
3.		
4.		

CONSENT TO TREATMENT

I hereby authorize Grand Peaks Medical and Dental and its affiliated Providers and staff to examine, test, and treat me or my dependent(s) for any medical, dental and/or behavioral/mental health condition. No guarantees have been made to me regarding my treatment or examination. In case of an emergency, in which I cannot be reached, I further authorize Grand Peaks Medical and Dental to treat my dependent(s).

AUTHORIZATION FOR ELECTRONIC COMMUNICATIONS

Grand Peaks Medical and Dental may communicate with our patients via electronic communications, which may include email, patient portal, and/or text. All communication is kept strictly confidential. Such communications sent thru the internet or over phone systems may not be encrypted or secure and could result in unauthorized persons retrieving your information. Grand Peaks is not responsible for the device that the patient receives communication on.

I understand the above policies.

Patient/Authorized Representative Signature Printed Name Date

Relationship to Patient: _____

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	***Date of Birth:***

I authorize (Provider name or Facility)_____

Address: _____**Phone #:**_____**Fax#:**_____

To provide my healthcare information via FAX to:
Grand Peaks Medical Dental Behavioral Health or Pharmacy (Upper Valley Community Health Services, Inc.) (208) 356-4900, at the following location(s):
Rexburg Location: 72 S 1st E, Rexburg, ID 83440
❑ Medical Fax (208) 356-3724 ❑ Dental Fax (208) 359-1600 ❑ Behavioral Health Fax (208) 624-4030
St. Anthony Medical, Behavioral Health and Pharmacy Locations: 335 E Main St., St. Anthony, ID 83445
❑ Medical Fax (208) 624-4116 ❑ Behavioral Fax (208) 624-4030 ❑ Pharmacy Fax (208) 624-4114
St. Anthony Dental Location: 325 E Main St., St. Anthony, ID 83445
❑ Dental Fax (208) 624-4117

To release the health information specified below:

❑ Entire medical record including patient healthcare history, office notes (except psychotherapy notes), test results, radiology studies, referrals, consultations, billing records, insurance records and records sent by other healthcare providers.

❑ Medical records from (Date)_____ to (Date)_____

❑ Description of information to be released: _____

_____

Purpose: ❑ Continuity of Care ❑ Self ❑ Other _____

TO BE READ AND SIGNED BY THE PATIENT:

I UNDERSTAND THE FOLLOWING:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- I understand that if I refuse to sign this disclosure, it will not affect my ability to obtain treatment.
- I understand that I may inspect or copy any information to be used or disclosed under this authorization.
- I understand that if the person or entity receiving this 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 federal privacy laws or regulations.
- I understand federal regulations require a description of how much and what kind of information is to be disclosed. Information relating to drug and alcohol abuse, confidential HIV related information and mental health treatment (except psychotherapy notes) will only be disclosed if stated above in the description.
- Please allow 30 business days for records to be prepared. There may be a charge for these services.
- *This authorization expires 1 year from the date signed unless terminated in writing.*

If I am authorizing the release of HIV related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Patient/Authorized Representative Signature Printed Name Date

Relationship to Patient: _____

Press the grey button to submit form via your email program

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