Brian W. Christensen M.D.

Board Certified General Surgeon
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20 Madison Professional Park
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HIPAA Notice of Privacy Practices

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control you protected health information. "Protected health information" is information about you, including demographic information that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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.

Payments: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare 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 activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose you protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. 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, as necessary, to contact you to remind you of your appointment. 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, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this 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: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiles in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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 the 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 a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of you protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications 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.

You have the right to have your physician amend 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.

You have the right to receive and accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003. Contact our HIPPA Compliance Officer with and questions or concerns: Sonja Mayfield, Sonja@madisonwomensclinic.com

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ DATE:_____

If you would like any of your medical or billing information from Brian W. Christensen's office shared with others, spouse, children etc. you will need to fill in the information below.

NAME: _____RELATIONSHIP:_____ DOB: _____

NAME: _____RELATIONSHIP:_____ DOB: _____

NAME: _____RELATIONSHIP:_____ DOB: _____

This HIPPA authorization will expire 5 years from the date signed.

Brian W. Christensen MD
20 Madison Professional Park
Rexburg, Idaho 83440
208-656-9008

Financial Policy

This is an agreement between Brian W. Christensen MD, as creditor, and the Patient/Debtor named on this form.

In this agreement the words “you,” and “your,” and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Brian W. Christensen MD.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payment options if you have no insurance:
1. You may choose to pay by cash, check, or credit card.
2. Unless we approve other arrangements in writing, payment is expected in full at the time of service.
3. On surgical procedures you may be required to pay 50% before the procedure and the balance in monthly payments approved by us in writing.
4. You may prefer to secure a bank, credit union, or other third party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:
1. You may choose to pay your deductible, co-pay and any out-of-pocket portions at the time services are rendered by cash, check, or credit card.

Co-payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, there will be a **processing charge of $5.00** for all co-pay’s not paid at the time of service.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the 15th of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or pre authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre authorization may result in a lower payment from the insurance company. If your insurance company requires a pre authorization, for a surgical procedure we will call and obtain the authorization.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered**.** If your insurance company requires a referral and/or pre authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre authorization may result in a lower payment from the insurance company. If your insurance company requires a pre authorization, for a surgical procedure we will call and obtain the authorization.

The Financial Policy continues on the backside of this page.

Medicare: I request that payment of authorized Medicare benefits be made to Dr. Brian Christensen for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Assignment and release: I hereby assign directly to Dr. Brian W. Christensen MD, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to patient responsibility. The **FINANCE CHARGE** will be computed at the rate of (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%) percent.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer fees which we incur plus all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Billing from other providers: If you have a procedure done you may receive bills from 1 or more of the following providers.

Madison Memorial Hospital 450 E Main Street Rexburg, Idaho 83440 208-356-3691
Madison Memorial Surgical Center 381 E 4th N Ste 200 Rexburg, Idaho 83440 208-359-2300
Madison Anesthesia Services Po Box 3882 Idaho Falls, Idaho 83403 208-525-2090
Idaho Falls Pathology Associates 2860 Channing Way Ste 117 Idaho Falls, Idaho 83404 208-529-6050
Teton Radiology 425 E 4th N Rexburg, Idaho 83440 208-356-4888

Patients name: _____

Responsible party
(If not the patient): _____

Signature: _____ Date: _____

BRIAN W. CHRISTENSEN MD
20 MADISON PROFESSIONAL PARK
REXBURG, IDAHO 83440
(208) 656-9008

Welcome to our office. In order to better serve you we need some information. I'm sorry but that means more paper work. Some of the paper work is so that we can bill your insurance company; it is much easier for you if we do this. The rest of the paper work is about your medical history so that Dr. Christensen can better understand you and your illness. Please be patient and complete the paperwork to the best of your ability. It is in your best interest to do so.

WHAT IS YOUR LEGAL NAME? _____ M / F

WHAT NAME DO YOU PREFERRED TO BE CALLED? _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

MAILING ADDRESS (If different than above) _____

PHONE NUMBERS:
HOME_____ CELL_____ WORK_____

EMPLOYER'S NAME _____

SPOUSE'S NAME _____

EMERGENCY CONTACT _____ PHONE # _____

WHO IS YOUR PRIMARY PHYSICIAN? _____

Race: White Hispanic Asian Native Hawaiian Black or African American Other Race Refused to report

Language: English Spanish Other

WHO IS YOUR PRIMARY INSURANCE COMPANY? _____

INSURANCE POLICY NUMBER? _____ GROUP # _____

WHO IS THE POLICY- HOLDER? _____
IF OTHER THEN YOURSELF PLEASE COMPLETE THE FOLLOWING

WHAT IS YOUR RELATIONSHIP TO THE POLICY- HOLDER? _____

WHAT IS THEIR SOCIAL SECURITY NUMBER? _____

WHAT IS THEIR DATE OF BIRTH? _____

WHO IS THE EMPLOYER OF THE POLICY- HOLDER? _____

ADDRESS OF POLICY- HOLDER _____
(€ CHECK HERE IF IT IS THE SAME ADDRESS AS ABOVE)

PHONE NUMBERS:
HOME_____ CELL_____ WORK_____

HOW DID YOU HEAR ABOUT US? Doctor Name_____ Yellow pages __ Internet__ Other_____

SIGNATURE_____

Email address_____

DATE_____

Name_____

Please list any medications that you are on.

Please list any allergies you have to medications including the type and reaction:

Please list any Surgeries you have had:

Last Mammogram: _____

Last Colonoscopy: _____

Preferred Pharmacy:_____

Please fill in all circles that apply to you:

asthma	O	allergies, seasonal	O
sleep apnea	O	bipolar disorder	O
thyroid nodule	O	kidney stones	O
breast lump	O	hiatal hernia	O
esophageal reflux	O	peptic ulcer disease	O
bowel disorders	O	irritable bowel syndrome	O
constipation	O	hemorrhoids	O
ulcerative colitis	O	Crohn's disease	O
small bowel obstruction	O	ischemic colitis	O
anemia	O	esophageal varices	O
gastroparesis	O	pyloric stenosis	O
cirrhosis	O	esophageal stricture	O
dementia	O	seizures	O
stroke	O	depression	O
heart attack	O	atrial fibrillation	O
mitral valve prolapse	O	heart murmur	O
high blood pressure	O	rheumatic heart disease	O
mitral valve regurgitation	O	mitral valve stenosis	O
congestive heart failure	O	ischemic heart disease	O
polycystic kidneys	O	renal failure	O
gout	O	systemic lupus erythematosus	O
hepatitis B	O	hepatitis C	O
AIDS/HIV	O	diabetes	O
High cholesterol	O	underactive thyroid (Hypo)	O
Overactive thyroid(Hyper)	O	protein C deficiency	O
Peripheral vascular disease	O	protein S deficiency	O

Please list any other significant health issues you may have:_____

_____

Please mark yes or no to **every** question:

Fatigue	O Yes O No	Fever	O Yes O No
Weight loss	O Yes O No	Night sweats	O Yes O No
Worsening Eyesight	O Yes O No	Difficulty swallowing	O Yes O No
Swollen glands	O Yes O No	Excessive thirst	O Yes O No
Heat intolerance	O Yes O No	Cough	O Yes O No
Pain with breathing	O Yes O No	Shortness of breath at rest	O Yes O No
Shortness of breath with exertion	O Yes O No		
Wheezing	O Yes O No	Chest pain at rest	O Yes O No
Chest pain with exertion	O Yes O No	Fluid accumulation in the legs	O Yes O No
Irregular heartbeat	O Yes O No	Palpitations	O Yes O No
Abdominal pain	O Yes O No	Constipation	O Yes O No
Diarrhea	O Yes O No	Rectal bleeding	O Yes O No
Nausea	O Yes O No	Vomiting	O Yes O No
Blood in stool	O Yes O No	Heartburn	O Yes O No
Change in bowel habits	O Yes O No	Easy bruising	O Yes O No
Prolonged bleeding	O Yes O No	Scrotal pain (men only)	O Yes O No
Hard testicle (men only)	O Yes O No	Blood in urine	O Yes O No
Difficulty urinating	O Yes O No	Frequent urination	O Yes O No
Change in mole(s)	O Yes O No	Rash	O Yes O No
Skin cancer	O Yes O No	Difficulty speaking	O Yes O No
Memory loss	O Yes O No	Seizures	O Yes O No
Mini Stroke (TIA)	O Yes O No	Fainting	O Yes O No
Depressed mood	O Yes O No	Loss of appetite	O Yes O No
Substance abuse	O Yes O No	Anxiety	O Yes O No
Bloody nipple discharge	O Yes O No	Breast lump	O Yes O No
Breast pain	O Yes O No	Breast swelling	O Yes O No
Nipple discharge	O Yes O No		

Please answer the follow questions

Are you: □ Single □ Married □ Widowed □ Divorced

What is your occupation _____

Does your family have a history of Malignant Hyperthermia □ Yes □ No □ Unknown

Please fill out the following information about your family members:

If you are adopted check here and ignore this section □

Father □ alive □ deceased □ colon cancer □ heart disease
□ high blood pressure □ diabetes □ stroke
□ other type of cancer list_____

Mother □ alive □ deceased □ colon cancer □ heart disease
□ high blood pressure □diabetes □ stroke
□ other type of cancer list_____

Sibling's □ alive □ deceased □colon cancer □ heart disease
□ high blood pressure □diabetes □ stroke
□ other type of cancer list_____

Paternal Grand Father (dad's father) □ alive □ deceased □ colon cancer □ heart disease
□ high blood pressure □diabetes □ stroke
□ other type of cancer list_____

Paternal Grand Mother (dad's mother) □ alive □deceased □colon cancer □ heart disease
□ high blood pressure □diabetes □ stroke
□ other type of cancer list_____

Maternal Grand Father (mom's father) □ alive □ deceased □ colon cancer □ heart disease
□ high blood pressure □ diabetes □ stroke
□ other type of cancer list_____

Maternal Grand Mother (mom's mother) □ alive □ deceased □ colon cancer □ heart disease
□ high blood pressure □ diabetes □ stroke
□ other type of cancer list_____

Have you used drugs other than those for medical reasons in the past 12 months □ Yes □ No

Did you have a drink containing alcohol in the past year? □ Yes □ No

If yes: how often did you have a drink containing alcohol?

- □ Monthly or less
- □ 2-4 times a month
- □ 2-3 times a week
- □ 4 or more times a week

If yes: How many drinks did you have on a typical day

- □ 1 or 2 drinks
- □ 3 or 4 drinks
- □ 5 or 6 drinks
- □ 7 to 9 drinks
- □ 10 or more drinks

If yes: How often did you have 6 or more drinks on one occasion

- □ Never
- □ Less than monthly
- □ Monthly
- □ Weekly
- □ Daily or almost daily

Are you a: □ Nonsmoker, □ Former smoker □ Current smoker

If former smoker when did you quit?_____

If current smoker: How often do you smoke?

- □ Every day
- □ Some days, but not every day

If current smoker: how many cigarettes a day do you smoke?

- □ 5 or less
- □ 6-10
- □ 11-20
- □ 21-30
- □ 31 or more

If current smoker: Are you: □ Ready to quit, □ Thinking about quitting,

□ Not ready to quit

Do you use other forms of Tobacco? □ Yes, □ No