

Patient Information

First Name: _____ MI: _____ Last Name: _____ DOB: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone: Home: _____ Cell: _____ SS# _____ Age: _____
Email: _____ Race: _____ Ethnicity: _____ Language: _____
Marital Status: _____ Employer: _____ Work Phone# _____ Circle one: (Male or Female)
Primary Care Physician: _____ Pharmacy: _____ City: _____
Emergency Contact: _____ Relationship: _____ Phone# _____
Parent/Guardian: _____ DOB: _____

Insurance Information:

Primary Insurance Company: _____ ID# _____ Group# _____
Subscriber's Name: _____ DOB: _____
Relationship to Subscriber: Self Spouse Child
Secondary Insurance Company: _____ ID# _____ Group# _____
Subscriber's Name: _____ DOB: _____
Relationship to Subscriber: Self Spouse Child

Medications: Please use the back if needed or attach a medication list.

Medication:	Dosage:	How often:

Allergies to Medications:

Medication:	Reaction:

Previous Surgeries:

_____ Date: _____
_____ Date: _____

Have you had any problems with anesthesia (numbing or put to sleep) **Yes** **No**

If yes, please explain _____

Non-Surgical Hospitalization: Reason _____ Date: _____

Have you had any of the following:

Pneumonia vaccine? **Yes** **No** Date: _____ Influenza Vaccine? **Yes** **No** Date: _____

Colonoscopy cancer screening? **Yes** **No** Date: _____ Breast cancer screening? **Yes** **No** Date: _____

Reason for Visit: _____

HIPAA PRIVACY PRACTICE

Patient Printed Name: _____ Date of Birth: _____

Initial: _____ I acknowledge that a copy of Valley Facial Plastics & ENT's Notice of Privacy Practice is posted in the waiting room and is available upon request.

PERSON(S) AUTHORIZED ACCESS TO MY MEDICAL INFORMATION

Initial: _____ I voluntarily authorize and request to disclose, discuss with provider or obtain my medical records (including paper, oral, and electronic interchange) to the following person(s) with the understanding that these records may include information related to AIDS or HIV, psychiatric or mental health information, and drug or alcohol information:

1. Name: _____ Phone: _____
Relationship to patient: _____
2. Name: _____ Phone: _____
Relationship to patient: _____

Initial: _____ I choose NOT to authorize any person(s) at this time to have access to my Health information.

NOTICE OF DISCLOSURE OF FEE/PAYMENT POLICY

Initial: _____ I understand that I'm responsible for the payment of all services rendered. Valley Facial Plastics & ENT participates in most insurance plans and will file your insurance for all plans. We do require all CO-PAYMENTS be paid in FULL at the time medical services are rendered. If there is a remaining balance after your insurance carrier pays, you will be billed, and payment is due upon receipt. Self-pay patients are required to pay at the time of service. Payments made in full are eligible for a 20% discount (this discount does not apply to the purchase of hearing aids and hearing aid accessories and other supplies or medications). If you cannot pay in full, we require a \$100 deposit for all new patients and \$50 for established patients. If you need to make special payment arrangements, it is your responsibility to contact the billing department prior to your appointment.

MULTI-SPECIALTY PRACTICE

Initial: _____ I am aware that Valley Facial Plastics & ENT is a multi-specialty practice, and that I may be billed for more than just an office visit. Additional charges may include audiometry, binocular microscopy, cerumenectomy, nasal cautery, laryngoscopy, injection of medications, biopsy, fine needle aspiration, post-surgical debridement, and ultrasound. These are not inclusive of all the additional charges that may be billed separately from an office visit. I understand that the cost of care will be based upon treatment rendered at the time of service.

Patient Consent to Treat and Obtain Medical/Medication History Electronically

Initial: _____ I authorize Valley Facial Plastics & ENT to request and use medication and medical information electronically from pharmacies and other healthcare providers that may be used in my care at Valley Facial Plastics & ENT.

Patient/Guardian Signature: _____ Date: _____

Medicare Lifetime Assignment and Medigap Authorizations

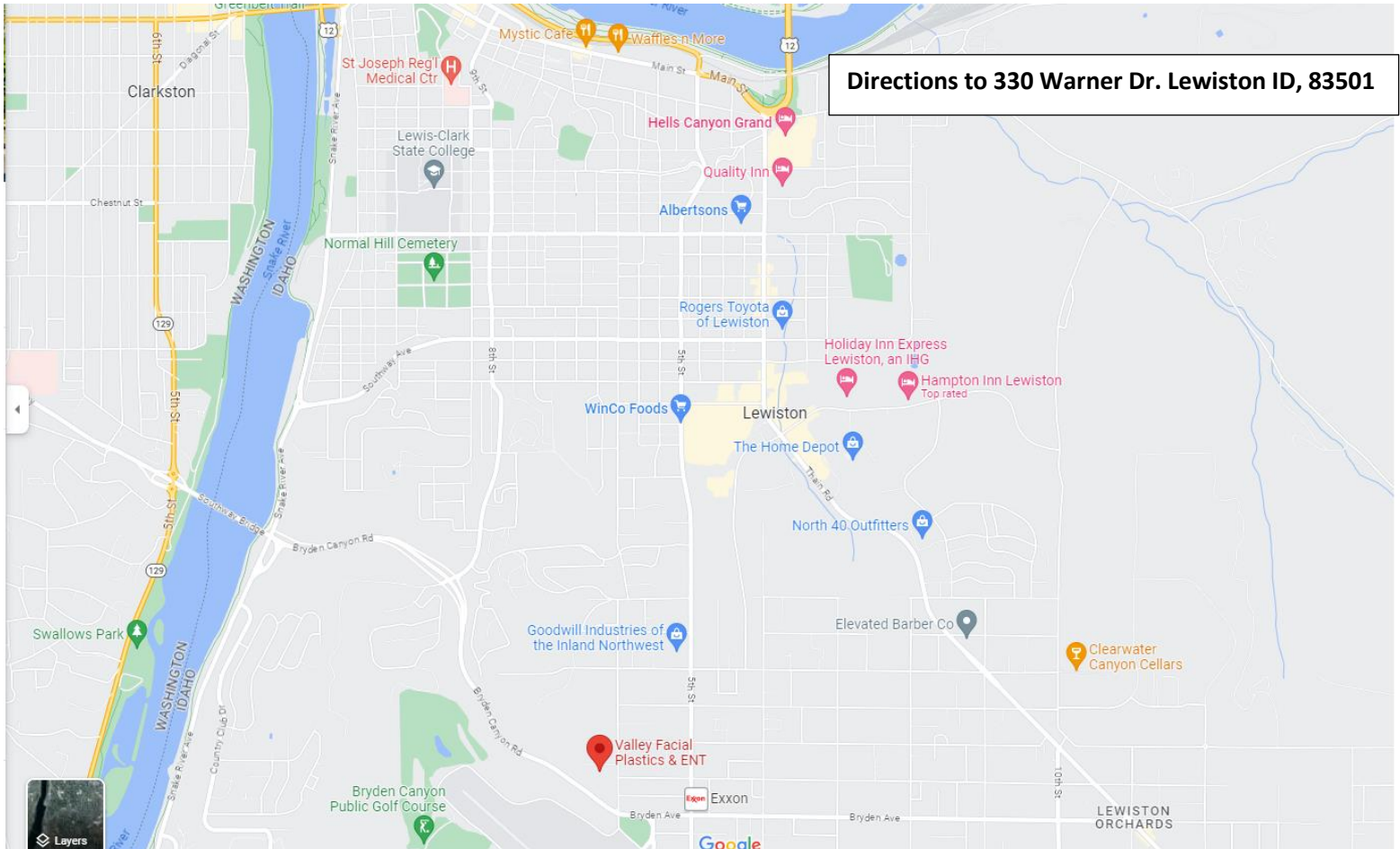
This section applies to Medicare patients only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Valley Facial Plastics & ENT for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap (my secondary insurance carrier) be made either to me or on behalf to Valley Facial Plastics & ENT for any services furnished me by that provider. I authorize any holder of medical information about me to release to _____ (name of secondary insurance needed to determine these benefits or the benefits payable for related services).

Patient/Guardian signature: _____ Date: _____

Directions to 330 Warner Dr. Lewiston ID, 83501



From Clarkston:

Take Snake River Ave and Bryden Canyon Rd to 4th St in Lewiston

8 min (4.5 mi)

↑ Head northeast on Diagonal St toward 5th St

0.3 mi

↗ Use the right 2 lanes to turn slightly right onto US-12 E/Bridge St

📍 Continue to follow US-12 E

📍 Entering Idaho

0.4 mi

↘ Turn right onto US-12/Snake River Ave

📍 Continue to follow Snake River Ave

1.4 mi

🔄 At the traffic circle, take the 1st exit and stay on Snake River Ave

0.6 mi

↶ Turn left onto Southway Bridge

0.1 mi

↘ Turn right onto Bryden Canyon Rd

1.7 mi

Continue on 4th St to your destination

From Asotin:

↑ Head west on 2nd St toward Washington St

6 sec (157 ft)

↘ Follow WA-129 N to Fleshman Way/Southway Bridge in West Clarkston-Highland. Take the exit toward Lewiston from WA-129 N

7 min (4.7 mi)

↘ Turn right at the 1st cross street onto Washington St

348 ft

↶ Washington St turns left and becomes WA-129 N/1st St

📍 Continue to follow WA-129 N

4.5 mi

🔄 At the traffic circle, take the 2nd exit onto the Fleshman Way/Southway Bridge ramp to Lewiston

0.1 mi

↘ Take Bryden Canyon Rd to your destination in Lewiston

4 min (2.4 mi)

↗ Merge onto Fleshman Way/Southway Bridge

📍 Continue to follow Southway Bridge

📍 Entering Idaho

0.5 mi

↑ Continue onto Bryden Canyon Rd

1.7 mi

↶ Turn left onto 4th St

0.2 mi

↶ Turn left onto Warner Dr

407 ft

↶ Turn left

📍 Destination will be on the left

From: Grangeville/Orofino

↘ Continue on US-12 W to Lewiston

46 min (42.1 mi)

↘ Turn right onto US-12 W (signs for Lewiston)

33.0 mi

↗ Slight right to merge onto US-12 W/US-95 N

📍 Continue to follow US-12 W

9.1 mi

↘ Continue on 21st St to your destination

8 min (2.9 mi)

↗ Slight left onto 21st St

📍 Pass by AutoZone Auto Parts (on the left in 0.5 mi)

0.9 mi

↘ Turn right onto 17th Ave

0.3 mi

↶ Turn left onto 17th St/5th St

0.8 mi

↘ Turn right onto Stewart Ave

0.2 mi

↶ Turn left onto 4th St

0.6 mi

↘ Turn right onto Warner Dr

407 ft

↶ Turn left

📍 Destination will be on the left

118 ft