Patient Registration Form

Patient Information		
Full Legal Name (First, Last, Middle):		
Previous Names:		Preferred Name:
Mailing Address:		City/State Zip:
Home Phone:	Cell Phone:	Preferred Method of Contact (circle one): **Voice or Text**
Email Address:		Date of Birth:
Sex Assigned at Birth (circle one): **Male Female**	Sex Listed with Insurance (circle one): **Male Female**	
Gender Identity (circle one): we ask about your gender identity to tailor our care to you. See the back of this form for more information. **Male Female Transgender Male (female-to-male) Transgender Female (male-to-female) Genderqueer (neither exclusively male or female) Don't Know/Unknown Other:_____ Choose Not to Disclose**		
Sexual Orientation: we ask you about your sexual orientation to ensure we provide personalized and inclusive care tailored to your needs. This information is protected and helps us better understand/support your health and well-being (circle one): **Straight or Heterosexual Bisexual Lesbian, Gay or Homosexual Don't Know/Unknown** **Other:_____ Choose Not to Disclose**		
Social Security #:	Family Physician or Pediatrician:	
Marital Status:	Preferred Language:	Translator Needed (circle one): **Yes No**
Preferred Pharmacy:		Employer:
Race (circle one): **White Hispanic Asian American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander** **Other:_____ Decline**		Ethnicity (circle one): **Hispanic or Latino Not Hispanic or Latino Decline**
Emergency Contact Name/Relationship:		Emergency Contact Phone #:

Responsible Party Information (for minor patients under the age of 18, the parent/guardian bringing the patient in will be listed as the guarantor)		
Full Legal Name (First, Last, Middle):		
Date of Birth:	Social Security #:	Phone:
Mailing Address:		City/State/Zip:
Relationship to Patient:		

	Primary Medical Insurance	Secondary Medical Insurance
Ins Company Name:		
Subscriber/ID #:		
Group #:		
Policy Holder Name:		
Policy Holder Date of Birth:		
Policy Holder Social Security #:		
Patient Relationship to Policy Holder:		

Patient Registration Form

I certify that I have read and agree to Primary Health Medical Group's (PHMG) payment policy. I assign to PHMG all money and benefits to which I am entitled for services provided, not to exceed my total balance, including if I am uninsured, have inactive, unverifiable, out-of-network, or non-accepted insurance. A down payment is required and will be applied to my charges; I am responsible for any remaining balance. If I later provide valid insurance, PHMG will assist in submitting a claim, but any uncovered amounts remain my responsibility. Any overpayments will be refunded once claims are processed. I understand I have the right to request a Good Faith Estimate under the No Surprises Act. For more information, visit www.cms.gov/nosurprises or primaryhealth.com/good-faith-estimate. I authorize PHMG to release any medical information to my insurance carrier or any third-party payer for insurance claim processing. I understand that failure to pay balances within 90 days of notifications will result in referral to an outside collection agency. A $30 fee will apply to checks returned for insufficient funds.

I consent to receive calls and text messages from PHMG, its affiliates, contractors, agents, successors, assigns, and any debt collectors acting on its behalf, at any phone number I provide now or in the future (including mobile, paging, or charge-incurring lines). These communications may include automated dialing systems, prerecorded or artificial voices, or messages generated by artificial intelligence, and may relate to appointments, treatment, feedback, or billing. I understand these messages may not be secure and may be accessed by unintended parties. Comments submitted on surveys may be anonymously shared on PHMG's public website. This consent applies to both calls and texts, regardless of Do-Not-Call registration, and I waive any claims under the Telephone Consumer Protection Act (47 U.S.C. § 227) or similar laws.

As required by the Idaho Patient Act, I acknowledge that I will receive a bill from: Primary Health Medical Group, 10482 W. Carlton Bay Dr., Garden City, ID 83714 | Phone: 208-955-6470. If applicable, I may also receive a bill from: Interpath Laboratory, P.O. Box 1208, Pendleton, OR 97801 | Phone: 866-289-4093 (This includes patients with Medicare, Medicare Advantage, Medicaid, Aetna, Regence, UMR, PEHP, MS Administrative Services, or UnitedHealthcare).

Medicare Beneficiaries: I request that authorized Medicare payments be made to PHMG and authorize the release of medical information to CMS and its agents as needed to process these benefits.

Why am I being asked about my sexual orientation and gender identity?
Each patient has unique health needs. Lesbian, gay, bisexual, and transgender (LGBT+) individuals often have different health needs. Understanding sexual orientation and gender identity helps us provide appropriate healthcare services and culturally sensitive care to all our patients.

What is gender identity?
Gender identity is someone's inner sense of their gender. For example, a person may think of themselves as male, as female, as a combination of male and female, or as another gender.

What does transgender mean?
Transgender people have a gender identity that is not the same as their sex at birth.

- Transgender Male describes someone assigned female at birth who has a male gender identity.
- Transgender Female describes someone assigned male at birth who has a female gender identity.
- Genderqueer and non-binary describe someone who has a gender identity that is neither male nor female or is a combination of male and female.

How do I choose the correct information?
There are no right or wrong answers. If you don't find an answer that fits, you can choose "Other," or "Don't know/ Unknown," or you can talk with your provider.

Who will see this information?
Your provider(s) and other staff associated with your care will see this information, and it will become part of your medical record. Your information is confidential and protected by law, just like all your other health information.

What if I don't want to share this information?
You have the option to check the box, "Choose not to disclose." Later, your provider may ask you these questions privately during your visit. You can choose whether to share this information at that point and/or you can ask your provider more questions.

How will this information be used? Your provider(s) will use this information to help meet your healthcare needs. In addition, gathering this information from all patients allows the health center to see if there are gaps in care or services across different populations. This helps us improve the care we give to our patients.

I have reviewed a copy of Primary Health Medical Group's Privacy Notice (initial please):	Date:
Signature of Responsible Party:	
Printed Name of Responsible Party:	