Teton Valley Health
Direct Primary Care

PATIENT CONSENT (**MUST FILL IN**)

PATIENT NAME**			MAILING ADDRESS	
CITY	STATE	ZIP CODE	SEX	DATE OF BIRTH**
			☐ M ☐ F	
SOCIAL SECURITY #**			PHONE #**	EMAIL

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT NAME**	PHONE #	RELATIONSHIP TO PATIENT

GUARANTOR/ LEGAL REPRESENTATIVE INFORMATION (IF APPLICABLE)

PATIENT/GUARANTOR NAME**			MAILING ADDRESS (IF DIFFERENT FROM PATIENT)	
CITY**	STATE**	ZIP CODE**	SEX	DATE OF BIRTH**
			☐ M ☐ F	
SOCIAL SECURITY #**			HOME PHONE #**	RELATIONSHIP TO PATIENT

Consent and Authorization

I, the undersigned, as legal representative for the above-named patient, do hereby request, consent to and authorize all medical tests, labs, and treatment including supplies and equipment, as may be prescribed and performed by staff physicians, practitioners, assistants, medical students and/or Cache Clinic employees/volunteers as deemed necessary in his/her judgment. I acknowledge that no assurances or guarantees have been made as to result of these medical services. I also understand that I, as legal representative have the right to refuse any treatment, procedure or medical services offered to the above-named patient and will accept full responsibility for consequences resulting from any such refusal.

I also understand that Cache Clinic, LLC is a separate entity operating independently from Teton Valley Health Care, Inc.

Release of Information

I agree to release any or all of the above-named patient's medical records, for this encounter, to Teton Valley Health Care, Inc. I also give permission for Cache Clinic, LLC to access medical records located at Teton Valley Health Care, Inc. for information to appropriately diagnose, treat and care for this patient.

Account Responsibility

I understand and agree that I am responsible for the balance on my account for any service rendered at the time of service.

With the undersigned signature, I verify that I have read and fully understand this form:

PATIENT SIGNATURE	DATE	
PARENT/GUARDIAN/LEGAL REPRESENTATIVE	DATE	WITNESS SIGNATURE

Teton Valley Health
Direct Primary Care

852 Valley Center Dr. • Driggs, Idaho 83422 • (208) 354-1156 • (208) 354-1155 (fax)

JOINT 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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

This Joint Notice of Privacy Practices applies to Teton Valley Health Care, Inc (hospital and clinics), Cache Clinic, and its medical staff members and others who provide health care at TVHC.

1. Uses And Disclosures We May Make Without Written Authorization. The persons to whom this joint notice applies may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.
Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain preauthorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.

- To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
- To contact you to raise funds for Teton Valley Health Care (TVHC). You may opt out of receiving such communications at anytime by notifying the Privacy Officer identified below.

3. Uses and Disclosures With Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
- We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
- You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
- You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete.
- You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
- You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes To This Notice. We reserve the right to change the terms of this Notice at anytime, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact: TVHC Privacy Officer at 208-354-2383.

8. Effective Date. This Notice is effective 10/17/16.

ACKNOWLEDGMENT

PRINTED NAME OF PATIENT	DATE	SIGNATURE OF PATIENT OR PATIENTS GUARDIAN

Teton Valley Health
Direct Primary Care

Please select one of the packages below. These charges are a monthly rate that will be automatically withdrawn from your account on the first business day of each month. If for any reason the payment does not go through the agreement for your Direct Primary Care Plan with be voided.

You may continue to be seen at the Cache Clinic but will be charged the $50 per visit plus any additional costs that maybe associated with the services rendered during the visit. By signing this agreement you give TVH consent to charge your credit card or debit card the monthly amount designated below.

	ONE CHILD	$35
	TWO CHILDREN	$70
	THREE CHILDREN	$105
	FOUR CHILDREN	$140
	ONE ADULT	$75
	FAMILY	$150
	TOTAL	$

PLEASE INCLUDE ALL FAMILY MEMBERS THAT ARE INCLUDED ON THE PLAN

Name (First and Last)	Date of Birth	Phone Number	Relationship

CREDIT CARD OR DEBIT CARD INFORMATION

CARD TYPE (MASTERCARD VISA, ETC)	CARD NUMBER	EXPIRATION DATE	SECURITY CODE

GUARANTOR SIGNATURE	DATE