BOISE STATE UNIVERSITY
HEALTH SERVICES

Patient Health History

Name:_____

University ID:_____

Phone Number:_____

Email Address:_____

Date of Birth: _____/_____/_____ **Sex:** M: ☐ F: ☐

Marital Status: Single: ☐ Married: ☐ Divorced: ☐

Long-term illness or condition, or any problem requiring regular treatment/care? (stomach, heart, headaches, weight, mental health/depression, blood pressure, asthma, etc.) None: ☐

If yes, please list:_____

_____

_____

Allergies to Medications: None: ☐

If yes, please list:_____

_____

Other Allergies: Seasonal: ☐ Other: ☐ None: ☐

If yes, please list:_____

_____

Current Medications *(name, dose)*: None: ☐

Prescriptions (Includes Birth Control):_____

_____

_____

Over the counter/herbal:_____

_____

Past history of serious illness or trauma *(broken bones, concussions, pneumonia, etc.)*: None: ☐

If yes, please list:_____

_____

Has anyone in your family had: cancer, heart disease, high blood pressure, diabetes, thyroid problems, mental illness, or <u>other</u> inherited conditions? None: ☐

If yes, please list relative & condition:_____

_____

_____

Past surgeries and/or hospitalizations (please list with date): _____

_____

_____

Tobacco/Nicotine Use: Never: ☐ Past: ☐ Current: ☐

Type: Cigarettes/Cigar/Pipe: ☐ Smokeless: ☐ Vaping: ☐

Quit when: _____

How many:_____ Per:_____

How long:_____

Alcohol Use:

How many drinks do you average in a day? _____ A week? _____

How often do you binge drink (more than 4-5 drinks in one night?

_____

Street/Recreational/Illicit Drug Use: No: ☐ Yes: ☐

IV Drug Use: No: ☐ Yes: ☐

What kind: _____

How much: _____

How long: _____

Is someone repeatedly following or watching you, showing up unexpectedly, or communicating with you in a way that seems obsessive or makes you concerned for your safety? Yes ☐ No ☐

Screening for anxiety and depression: Over the past **2 weeks**, how often have you been bothered by any of the following items?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐ *0*	☐ *1*	☐ *2*	☐ *3*
2. Not being able to stop or control worrying	☐ *0*	☐ *1*	☐ *2*	☐ *3*
3. Little interest or pleasure in doing things	☐ *0*	☐ *1*	☐ *2*	☐ *3*
4. Feeling down, depressed, or hopeless	☐ *0*	☐ *1*	☐ *2*	☐ *3*

Females Only: # of pregnancies: _____ # of live births: _____

Menses regular? No: ☐ Yes: ☐

First day of last menstrual period? _____/_____/_____

Signature: _____

Date:_____/_____/_____

BOISE STATE UNIVERSITY
HEALTH SERVICES

Eating Attitudes Test

	Behavioral Questions: In the past 6 months have you:	Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A	Gone on eating binges where you feel that you may not be able to stop?*	☐	☐	☐	☐	☐	☐
B	Ever made yourself sick (vomited) or withheld food to control your weight or shape?	☐	☐	☐	☐	☐	☐
C	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	☐	☐	☐	☐	☐	☐
D	Exercised more than 60 minutes a day to lose or to control your weight?	☐	☐	☐	☐	☐	☐
E	Lost 20 pounds or more in the past 6 months?	Yes ☐	No ☐				
*Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control							

Hunger Vital Sign

Within the last 12 months, we worried whether our food would run out before we got money to buy more.
(Please circle one below)

Often true ☐ Sometimes true ☐ Never true ☐ Don't know ☐

Within the past 12 months, the food we bought just didn't last and we didn't have any money to get more.
(Please circle one below)

Often true ☐ Sometimes true ☐ Never true ☐ Don't know ☐

I, _____ agree to have my counselor/medical provider communicate with Boise State University's Student Outreach and Assistance team about my desire to be contacted by them to help address concerns about my food insecurity.

- I understand that only students can access this assistance.
- I understand that nothing about my care at Health Services will be shared with the Student Outreach and Assistance team beyond my name, contact information, and desire to receive pertinent assistance provided by their office.

_____ _____

Printed Patient Name Patient Signature

_____ _____

University ID Number Date

BOISE STATE UNIVERSITY

HEALTH SERVICES

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.

Protecting Your Personal and Health Information

Boise State University Health Services ("Health Services") is required by applicable federal and state laws to maintain the privacy of your protected health information, and to notify affected individuals following a breach of unsecure health information. This notice explains our privacy practices, our legal duties, and your rights concerning your health information. Our duties and your rights are set forth more fully in 45 CFR Part 164. While this policy is in effect, we are required by law to abide by its terms.

Uses and Disclosures We May Make Without Written Authorization

For certain purposes Health Services may use and or disclose your health information without your written authorization. These include the following circumstances:

- **Treatment:** We may use and disclose your health information to provide treatment to you, or for continuation of treatment activities.
  For Example: We may share your information with another healthcare provider so they may treat you.

- **Payment:** We may use and disclose your health 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 pre-authorization or payment for treatment.

- **Health Care Operations:** We may use and disclose your health 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. We may also call you by name in the waiting room when Health Services staff is ready to see you.

Other Uses and Disclosures

Health Services may also use or disclose your information for certain other purposes as allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid serious threat to your health or safety or the health and safety of others.

- As required by state or federal law such as reporting abuse, neglect or certain other events.

- 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.

Effective date of this notice: July 1, 2023

1910 University Drive Boise, Idaho 83725-1351
Phone (208) 426-1459 Fax (208) 426-3005

- 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, such as 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.
- Scheduling and appointment reminders
- Plan Sponsors: If you are enrolled in the Graduate Assistant or International Student Health Insurance plans, we may disclose your health information to the sponsor to permit it to perform administrative activities.
- Underwriting: We may receive, use and disclose your health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of the contract for SHIP.
- If you are a minor: Some state laws concerning minors permit or require disclosure of protected health information to parents, guardian, and persons acting in a similar legal status. We will act consistently with the laws of Idaho and will make disclosures consistent with such laws.
- To your family and/or friends in the event of an emergency.

Disclosures We May Make Unless You Object:
Unless you notify us otherwise in writing, we may disclose your information as described below:

- For marketing purposes: Such as to inform you of health related products and services or about treatment alternatives that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you with the choice to opt out of those activities. You may also choose to opt back in.
- To maintain a facility directory: If a person were to ask for you by name, we will only disclose if you were seen at Health Services.

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 disclosures of psychotherapy notes (if the provider you saw kept psychotherapy notes), 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 of the authorization.

Your Patient 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 HIPAA Privacy Compliance Officer.

- You may inspect and obtain a copy of your records that are used to make decisions about your care, or payment for your care. We may deny your request under certain circumstances. For example: if we determine that disclosure may result in harm to you or others.

Effective date of this notice: July 1, 2023

- You may request that your protected health information be amended. We may deny your request for certain reasons such as: if we did not create the record or if we determine that the record is accurate and complete.

- You may request an accounting of disclosures we have made of your protected health information.

- You may request additional restrictions on the use or disclosure of information for treatment, payment or health care operations. However, we are not required to agree to the restrictions except in the limited situation in which you, or someone on your behalf pays for an item or service in full, and you request that the information concerning such item or service not be disclosed to a health insurer.

- We normally contact you by telephone, text message, email, or at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.

- You have the right to obtain a paper copy of this Notice upon your request. You have this right even if you have agreed to receive the Notice electronically.

- You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached.

Communication through Email

We ask you not to use your personal email in contacting our staff. Emails sent to and from your personal email address are not secure and could be intercepted by a third party. We strongly encourage you to sign up for a patient portal account where you can read and respond to emails you receive from us, check your lab results, see your appointment summaries and check on your past and upcoming appointments. If you should have further questions we ask that you call our office directly so we can assist with answering your questions and taking care of your needs.

Changes to this Notice of Privacy Practices

Boise State University Health Services reserves the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that it maintains. If we materially change our privacy practices, we will post a copy of the current Notice on our website and all other locations which this Notice is posted. Until such time, Boise State University Health Services is required by law to comply with the current version of this Notice.

Complaints

If you have any questions regarding this Notice or if you feel any of your rights listed in this Notice have been violated you may file a complaint with the Secretary of Health and Human Services or by notifying our HIPAA Privacy Compliance Officer. All complaints must be in writing. We will not retaliate against you for filing any complaints.

Boise State University Health Services
Attn: HIPAA Privacy Compliance Officer
1910 University Drive
Boise, ID 83725-1351
Phone (208) 426-1459
Fax (208) 426-4059

Office for Civil Rights, Region X-Seattle
U.S. Department of Health and Human Services
Sharon D. Turner, Acting Regional Manager
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831
Phone: (206) 615-2010
Fax: (206) 615-2087

Signature:_____ Date:_____ University ID:_____

Effective date of this notice: July 1, 2023

BOISE STATE UNIVERSITY
HEALTH SERVICES

HEALTH SERVICES PATIENT/CLIENT AGREEMENT

Thank you for choosing Boise State University Health Services as your health care provider. We are committed to providing you with quality health care.

Hours of Operation: Health Services is open from 8:00am to 5:00pm on Monday, Tuesday, Thursday, Friday, and from 10:00am to 5:00pm on Wednesday. Crisis counseling and urgent care medical services are available during the hours of operation; **no appointment is required.** Crisis counseling and urgent care medical services are meant for situations which cannot wait for a scheduled appointment.

Consent for Treatment: I authorize the staff of Boise State University Health Services, their employees, and consultants to undertake such treatment, diagnostic procedures, and medical procedures, which in their judgment may become necessary while receiving care at Health Services. I understand that I will be involved and engaged in my care and treatment; and that I have a right to a full explanation of any treatment or procedures utilized. I am aware the practice of medicine is not an exact science and I understand no guarantees have been made to me regarding the results of treatment or examinations. As a patient/client of Health Services, I understand that individuals being trained for a health care profession may participate in providing me care. I understand that if I require specialized care, emergency care, or care which is out of the scope of services for Health Services I will be referred to the appropriate facility and/or providers. I understand that an emergency contact will be notified of my condition if considered necessary by the professional staff at Health Services.

Confidentiality and Notice of Privacy Practices Acknowledgement: Medical and mental health information contained in all health records is confidential and may not be released without express written permission from the patient/client unless certain conditions are met.

- Where there is reasonable suspicion or report of abuse to vulnerable populations, including children, elderly persons, and individuals who are unable to advocate for themselves.
- Where you present serious and foreseeable harm to yourself or others.
- If we receive a subpoena, court order, or as part of legal proceedings which may include but is not limited to legal complaints filed by you against your provider.
- In specific cases of law enforcement emergency for national security issues.

In rare circumstances where the University receives report of concerning behavior that could put your welfare or the safety of others at risk, Health Services may disclose to the C.A.R.E. Team information about your appointment-attendance history; no other information about your care or treatment will be disclosed.

I understand that Health Services may release my health records (with the exception of psychotherapy notes) for treatment, payment, or health care operations, and for certain other purposes under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable federal or state laws and regulation. I also understand that I have certain rights to privacy in regard to my protected health information (PHI). I understand a copy of the Notice of Privacy Practices (Notice) which provides a comprehensive description of how my health information may be used and/or disclosed is available to me at my first appointment and upon request. I understand that I have the right to review the Notice prior to signing this acknowledgement form. I understand that Health Services reserves the right to change their notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, orhealth care operations, and that Health Services may not be required to agree with the restrictions I have requested.

Notice of Nondiscrimination and Accessibility: Boise State University Health Services ("Health Services") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Services:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats
  - Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, please let us know upon scheduling your appointment.

If you believe that Health Services has failed to provide these services or discriminated against you or others in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: (Name and Title of Civil Rights Coordinator, mailing address, phone number, fax, email). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, (Name and Title of Civil Rights Coordinator) is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil rights Complaint Portal, available at https://ocrportal.hhs.gove/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1(800)368-1019, (800)537-7697 (TDD)

BOISE STATE UNIVERSITY
HEALTH SERVICES

REGARDLESS OF STUDENT STATUS

PLEASE INITIAL FOR EACH BOX

Patient Financial Agreement and Acknowledgement of Office Policies: This agreement between Health Services and you, the patient, or the responsible party is provided to inform you of our financial policies. A complete version of this agreement is available upon request.

____ **FEES**: I understand that Health Services is a fee-for-service clinic and bills for its services. I understand that there may be additional 3rd party fees from outside facilities such as a lab, pharmacy, or other community providers, which are separate from Health Services.

____ **INSURANCE**: Health Services will attempt to bill your insurance. However, it is your responsibility to understand your insurance benefits and coverage, so please check with your insurance before receiving services. Health Services does not bill or accept Medicare, VA, or out-of-state Medicaid.

____ **PAYMENT:** For currently enrolled students, any balance after insurance will be transferred to your student account. Employees and non-enrolled students are expected to pay their copay and any other service we cannot bill to insurance on the date of service. All patients are to pay for medications at the time of service.

____ **SELF PAY:** You may decide to self-pay if you choose not to use your insurance, or if you are provided services for which we cannot/do not bill insurance, such as, but not limited to:

a) massage therapy
b) dispensary medications
c) dietitian services
d) flat fee physicals

_____**Proof of Insurance**: You will be asked to show a copy of your insurance card when you check-in. If you are unable to show your current insurance card, we allow 24 hours after the date-of-service for you to provide your insurance information to us.

Missed/Late Appointments: Please help us serve you better by keeping scheduled appointments and giving 24 hours' notice on any cancellations.

_____**I understand that I will be charged a $40 no-show fee for any missed appointments with Health Services.**

_____**I understand that I will be charged a $20 late cancellation fee for any appointment canceled within 24 hours of my scheduled appointment.**

_____**I understand that if I arrive more than 10 minutes late for a scheduled appointment, I will be rescheduled for that appointment.**

Thank you for reviewing our Patient/Client Agreement. Please let us know if you have questions or concerns regarding this information. By signing below, you agree to the information stated above.

_____ _____
Emergency Contact Name Relationship

_____
Phone number

_____ _____
Printed Patient/Client Name Date

_____ _____
Patient/Client Signature University ID Number

BOISE STATE UNIVERSITY

HEALTH SERVICES

RIGHTS AND RESPONSIBILITIES

Boise State University Health Services is committed to supporting and protecting the rights of each of our patient/clients. With these rights also come patient/client responsibilities. Active participation in your health care will assure the best outcomes.

PATIENT/CLIENT RIGHTS:

- To accept or refuse any care or treatment and understand the implication of refusal
- To receive fair and equal treatment in all circumstances regardless of your age, race, gender, sexual orientation, or religion
- To be treated with respect, consideration, and dignity
- To receive care in a safe environment
- To privacy of care
- To be informed of your provider's training status, including the limitations and restrictions of services
- To participate in decisions about your care and treatment
- To receive accurate, easily understood information about your health care concerns and the care you are receiving
- To be informed of the purpose, goals, techniques, procedures, limitations, potential risks, and benefits to treatment
- To ask questions about techniques and strategies used
- To work with your provider on a treatment plan you are comfortable with and will adhere to
- To receive education and counseling
- To request to transfer to another provider, when appropriate
- To confidentiality of your records
- To access your medical records
- To have your concerns heard and reviewed in an objective and timely manner
- To receive a copy of this consent form
- To file a complaint without retaliation

PATIENT/CLIENT RESPONSIBILITIES:

- To provide accurate information regarding your health history
- To be active in making decisions regarding your care
- To ask questions to seek clarification if you do not understand your treatment plan
- To follow the treatment plan prescribed by your health care provider
- To show courtesy and respect to health care personnel and other patient/clients
- To keep your appointments and arrive on-time
- To cancel or reschedule as far in advance as possible so that the time may be used to treat other patient/clients
- To communicate with your provider if your condition worsens or does not follow the expected course
- To provide useful feedback about services and policies
- To provide accurate information about sources of payment
- To fulfill your financial obligations and to pay for care as promptly as possible
- To inform your health care provider of any advanced directives that could affect your care

BOISE STATE UNIVERSITY

HEALTH SERVICES

Providers at Boise State University Health Services also have certain rights and responsibilities related to the care they provide to patients/clients. Creating a mutually respectful relationship with your provider will enhance the care you receive.

PROVIDER RIGHTS:

- To establish and maintain mutually respectful relationships with their patients/clients
- To consult with other medical and mental health providers within Health Services, when needed, in order to provide the best care for the patient/client
- To terminate a relationship with a patient/client if that patient/client's care is outside of the provider's scope of practice, or if the patient/client displays disruptive behavior, is a safety concern, or creates an ethical dilemma. In these cases, patients/clients will be provided appropriate referrals that would best meet their needs

PROVIDER RESPONSIBILITIES:

- To adhere to all statutes, licensing board rules, and codes of ethics in the provider's field of practice
- To present patients/clients documents related to professional qualifications upon request
- To provide quality services and involve patients/clients in their plan development and evaluation of treatment goals
- To ensure confidentiality of their patient/client's clinical information whenever possible
- To inform the patient/client of provider qualifications, professional disciplines, areas of expertise, and to practice within those standards
- To demonstrate respect regardless of a patient/client's age, race, ethnicity, gender, sexual orientation, religion, and socio-economic status

I have read and understand the rights afforded to me as a patient/client and the responsibilities I have while I receive care.

I understand that typing my name below suffices as my manual signature. My signature indicates that I have read this agreement, agree to the terms, and have had the opportunity to have my questions answered.

_____ _____

Patient/Client Signature Date

_____

University ID Number

BOISE STATE UNIVERSITY

HEALTH SERVICES

Lab Billing Notice

While you are receiving care at Health Services, your provider may request laboratory or other diagnostic services be performed. Below are some key pieces of information regarding billing and payment for these services.

- Health Services partners with outside labs to perform most tests.
  - This means that we will draw your blood, collect the specimen, etc… but may not perform the actual tests at our facility.

- **You will receive a separate bill from the lab that performed your outside tests.**
  - **Many times, these lab/diagnostic services are applied to your deductible.**
  - **You will be responsible for any balance owed related to lab tests performed.**
  - **Contact your insurance carrier for more information on your specific plan.**

- If you **do not** want your lab services billed to your insurance, please let the staff know at the time the specimen is collected.

- If you have any questions regarding the billing of your labs, please call the number provided on the statement you receive from the lab.

For further questions or concerns please contact our billing department at (208) 426-2158 or healthinsurance@boisestate.edu.

By signing below, you acknowledge that you have read and understand the information outlined above.

_____ _____

Printed Patient Name Date

_____ _____

Patient Signature University ID Number