

### Adult Patient Demographics

<b>Patient Name:</b> _____	<b>DOB:</b> _____
<b>Address:</b> _____	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
_____	<b>Home Phone:</b> _____
<b>Work Phone:</b> _____	<b>Cell Phone:</b> _____
<b>Physician:</b> _____	<b>Office Phone:</b> _____
<b>Referred By:</b> _____	<b>Primary Language:</b> _____
<b>Patient is:</b> <input type="checkbox"/> ISU Student <input type="checkbox"/> ISU Faculty/Staff <input type="checkbox"/> ISU Faculty/Staff Family Member <input type="checkbox"/> N/A	

### Insurance Information

<b>Insurance Provider(s):</b> (Please check all that apply)				
<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Regence BS	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Pacific Source
<input type="checkbox"/> Select Health	<input type="checkbox"/> VA	<input type="checkbox"/> Ameriben	<input type="checkbox"/> UHC	<input type="checkbox"/> Tricare
<input type="checkbox"/> Private Pay	<input type="checkbox"/> Student Health	<input type="checkbox"/> Other: _____		
<b>Primary Subscriber ID:</b> _____	<b>Group No.:</b> _____			
<b>Subscriber Name:</b> _____	<b>DOB:</b> _____			
<b>Secondary Subscriber ID:</b> _____	<b>Group No.:</b> _____			
<b>Subscriber Name:</b> _____	<b>DOB:</b> _____			
<b>Address:</b> (if different from above) _____				
<b>Employer:</b> _____	<b>Student Status:</b> <input type="checkbox"/> FT <input type="checkbox"/> PT			

### Billing Policy

We bill all major insurance companies. We recommend a physician's referral or prescription for services. **Medicaid patients are required to have a physician's referral and possibly a Healthy Connection.** All co-pays will be due after insurance has been billed and processed. If you do not have insurance and have limited financial resources, you may be able to qualify for a discount. If you qualify for a fee reduction, a partial payment may be due at the time of service. At a minimum, payments must be made monthly. All fees must be paid in full by the end of the semester to be eligible for continued services. Accounts past due more than 90 days will be sent to collections and any cash discounts applied will be removed and you will be responsible for regular therapy pricing.

### Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all charges regardless of insurance and understand the billing policy as stated above. I also understand that supervised graduate students may participate in the evaluation and treatment of the patient as part of their educational program, and hold ISU harmless for any incident related to this treatment.

<b>Signed By:</b> _____	<b>Date:</b> _____
<i>Patient/Guardian or Responsible Party</i>	

**Medications:**

**Are you currently taking any prescription medication?**  Yes  No If yes, please describe below.

	Prescription Name	Dosage Per Day	Purpose or Reason Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

**Are you currently taking any over the counter medication?**  Yes  No If yes, please list below.

	Medication Name	Dosage Per Day	Purpose or Reason Taken
1.			
2.			
3.			
4.			
5.			

**Drug Allergies:**

**Do you have any drug related allergies?**  Yes  No If yes, please list below with reaction.

1.	
2.	
3.	
4.	
5.	

**Health Problems:** (Please describe any health problems.)
