Idaho Falls Arthritis Clinic
2220 East 25th Street
Idaho Falls, ID 83404
Phone: (208) 542-9080
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Craig D. Scoville, MD, PhD

Patient Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability & Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____
Relationship to Patient (if patient is a minor): ____________________________
Signature: ____
Date: ____

I give Idaho Falls Arthritis Clinic or any of its affiliates, authorization to disclose my personal appointment and medical information to the individuals listed below (family members, spouse, etc.). I understand if their names are not listed here, no information will be shared without a signed consent from me.

Name ______________________________ Relationship ______________
Name ______________________________ Relationship ______________
Name ______________________________ Relationship ______________

I give Idaho Falls Arthritis Clinic or any of its affiliates, authorization to contact me in the following manners:

☐ YES ☐ NO Home number:______________________
☐ YES ☐ NO Cell Number:______________________ *text messages, charges may apply.
☐ YES ☐ NO Email:______________________
☐ YES ☐ NO Home Mail: ______________________

Please Complete the following:
Race: [ ] American Indian or Alaska Native [ ] Asian [ ]Native Hawaiian or Other Pacific Islander
[ ] Black or African American [ ]White [ ] Hispanic [ ] Other Race [ ] Other Pacific Islander

Ethnicity: [ ] Non-Hispanic or Latin [ ] Hispanic or Latin

Language: [ ] English [ ] Other [ ]Indian (Hindi & Tamil) [ ]Spanish [ ] Russian

Effective date September 24, 2019