New Patient Registration

Hayton Primary Care is an adult primary care practice serving patients age 18 and older.

Please complete all fields. Bring your insurance card(s) and a photo ID to your first visit.

PATIENT INFORMATION

FULL LEGAL NAME (FIRST, MIDDLE, LAST) | DATE OF BIRTH

PREFERRED NAME | PREVIOUS NAME(S) | MARITAL STATUS

SEX ASSIGNED AT BIRTH | SEX ON INSURANCE | GENDER IDENTITY | PRONOUNS

SOCIAL SECURITY NO. (OPTIONAL — USED ONLY TO MATCH RECORDS & VERIFY INSURANCE) | PREFERRED LANGUAGE

CONTACT INFORMATION

MAILING ADDRESS | APT / UNIT

CITY | STATE | ZIP

CELL PHONE | HOME PHONE | PREFERRED CONTACT (VOICE / TEXT)

EMAIL ADDRESS | PAPERLESS BILLING? (SEE FINANCIAL POLICY §14)

EMERGENCY CONTACT

NAME | RELATIONSHIP | PHONE

Contacted only if we cannot reach you in an urgent situation. This does NOT authorize us to share your health information with them — use the "People we may speak with about your care" section on the Consent page.

PREFERRED PHARMACY

PHARMACY NAME | CROSS STREETS / LOCATION | PHONE

PRIMARY INSURANCE

INSURANCE CARRIER | MEMBER / SUBSCRIBER ID | GROUP NUMBER

POLICYHOLDER NAME (IF NOT PATIENT) | POLICYHOLDER DATE OF BIRTH | RELATIONSHIP TO PATIENT

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE CARRIER | MEMBER / SUBSCRIBER ID | GROUP NUMBER

POLICYHOLDER NAME (IF NOT PATIENT) | POLICYHOLDER DATE OF BIRTH | RELATIONSHIP TO PATIENT

RESPONSIBLE PARTY / GUARANTOR (ONLY IF SOMEONE OTHER THAN THE PATIENT WILL PAY)

NAME | DATE OF BIRTH | RELATIONSHIP | PHONE

Sign only if you agree to be personally responsible for this patient's account under the Financial Policy. Leave blank if the patient pays their own account.

GUARANTOR SIGNATURE | PRINTED NAME | DATE

Medical History & Current Medications

Bring this completed form to your first visit. It helps Dr. Hayton build an accurate picture of your health.

PATIENT NAME | DATE OF BIRTH | TODAY'S DATE

REASON FOR TODAY'S VISIT / HEALTH GOALS

CURRENT MEDICATIONS

List all prescriptions, over-the-counter medicines, vitamins, and supplements. ☐ None ☐ See attached list

MEDICATION	DOSE	HOW OFTEN

ALLERGIES

Include medication, food, latex, and environmental allergies. ☐ No known allergies of any kind

ALLERGEN	TYPE (MED / FOOD / LATEX / ENVIRONMENTAL)	REACTION

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐ High blood pressure	☐ High cholesterol	☐ Diabetes
☐ Heart disease	☐ Heart failure	☐ Atrial fibrillation
☐ COPD / asthma	☐ Kidney disease	☐ Thyroid disease
☐ Cancer	☐ Stroke / TIA	☐ Depression
☐ Anxiety	☐ Chronic pain	☐ Arthritis / osteoporosis
☐ Substance use	☐ Sleep apnea	☐ Liver disease

OTHER CONDITIONS

SURGERIES & HOSPITALIZATIONS

PROCEDURE / REASON	APPROX. YEAR

Medical History, continued

PATIENT NAME | DATE OF BIRTH

FAMILY HISTORY (CHECK AND NOTE RELATION)

☐ HEART DISEASE — RELATION

☐ DIABETES — RELATION

☐ HIGH BLOOD PRESSURE — RELATION

☐ CANCER — RELATION

☐ STROKE — RELATION

☐ MENTAL HEALTH CONDITION — RELATION

SOCIAL HISTORY

Tobacco: ☐ Never ☐ Former ☐ Current _____ per day Alcohol: ☐ None ☐ Occasional ☐ _____ drinks/week

RECREATIONAL OR OTHER SUBSTANCES | EXERCISE

OCCUPATION | LIVING SITUATION

Do you have an advance directive or living will? ☐ Yes ☐ No Immunizations up to date? ☐ Yes ☐ No ☐ Unsure

PREVENTIVE CARE

LAST PHYSICAL EXAM | LAST DENTAL VISIT | LAST EYE EXAM

LAST COLONOSCOPY | LAST MAMMOGRAM / PAP (IF APPLICABLE) | LAST BONE DENSITY

ANYTHING ELSE YOU WOULD LIKE DR. HAYTON TO KNOW?

Consent to Treatment & Practice Acknowledgments

PATIENT FULL LEGAL NAME | DATE OF BIRTH | TODAY'S DATE

Hayton Primary Care serves patients age 18 and older. We do not accept patients under 18.

PART A — REQUIRED (CONDITIONS OF RECEIVING CARE)

1. Consent to treatment. I voluntarily consent to medical evaluation, examination, diagnosis, and treatment by Derek Hayton, D.O. and the supervised clinical staff of Hayton Primary Care / HPC Medical Group PLLC. I understand that the practice of medicine is not an exact science and results cannot be guaranteed; that I may refuse any recommended treatment and ask questions at any time; and that I may withdraw this consent in writing at any time, which will not affect care already provided.

2. Assignment of benefits & authorization to bill. I authorize Hayton Primary Care to bill my health plan(s), Medicare, Medicaid, and any other applicable payer on my behalf and to receive payment directly; to release the medical and billing information necessary to process claims, coordinate benefits, or obtain payment; and to photograph or scan my insurance card(s) and photo ID for identification and billing.

Medicare beneficiaries: my signature requests payment and authorizes release of information to process my claims. In assigned cases the physician accepts the Medicare-approved amount as full payment; I owe the applicable deductible, coinsurance, and non-covered services.

3. Financial Policy. I have read, or been offered the opportunity to read, the Financial Policy of Hayton Primary Care, and I agree to its terms — including that cost-sharing is due at the time of service; that I am responsible for charges my plan determines to be mine and for non-covered services I agree in advance to receive; that keeping a payment method on file is optional and not a condition of care; that there is no missed-appointment fee; and that self-pay patients receive a Good Faith Estimate.

4. Notice of Privacy Practices. I acknowledge that I have been offered a copy of the Notice of Privacy Practices, which describes how my health information may be used and disclosed and how I can access it. A copy is available at the front desk and at haytonprimarycare.com.

OFFICE USE ONLY — Notice of Privacy Practices acknowledgment: ☐ obtained ☐ patient declined ☐ not obtainable
If not obtained, reason: _____ Staff initials: _____ Date: _____

5. Communications. I authorize the practice to contact me about appointments, results, billing, and health-related matters using the contact information I provided. Standard text and data rates may apply. I may opt out of text messages at any time by telling the practice.

PART B — OPTIONAL (YOUR CHOICE)

Everything in this section is optional. Leaving any of it blank will not affect your care.

Messages, voicemail, and email. May we:

Leave appointment reminders on your voicemail or answering machine?	☐ Yes	☐ No
Leave detailed clinical or medication information on your voicemail?	☐ Yes	☐ No
Leave a message about appointments with a household member?	☐ Yes	☐ No
Contact you by email for health-related communications?	☐ Yes	☐ No
Send you information about Chronic Care Management (CCM)?	☐ Yes	☐ No

People we may speak with about your care.

NAME	RELATIONSHIP	WHAT MAY BE DISCUSSED (ALL / SCHEDULING / BILLING)	PHONE

NAME	RELATIONSHIP	WHAT MAY BE DISCUSSED	PHONE

Stays in effect until you change or cancel it — call (208) 247-4279 at any time.

By signing below, I confirm that I have read (or had read to me) and understand Part A, that my choices in Part B are my own, and that the information I have provided is accurate and complete.

SIGNATURE

PATIENT SIGNATURE | DATE

PRINTED NAME | DATE OF BIRTH

If the patient is unable to sign, a personal representative (legal guardian or agent under a health care power of attorney) signs here:

SIGNATURE OF PERSONAL REPRESENTATIVE	PRINTED NAME	RELATIONSHIP & LEGAL AUTHORITY	DATE

Telehealth Informed Consent

Read carefully. Sign only if you wish to use telehealth. You may ask questions at any time.

PATIENT FULL LEGAL NAME | DATE OF BIRTH | TODAY'S DATE

YOUR PROVIDER

Derek Hayton, D.O. · Idaho medical license no. _____ · Hayton Primary Care / HPC Medical Group PLLC, 300 W. Main St., Suite 100, Boise, ID 83702 · Phone (208) 247-4279

WHAT TELEHEALTH IS

Telehealth is health care delivered using technology that lets you and Dr. Hayton interact without being in the same place — for evaluation, diagnosis, treatment, education, and care management.

Audiovisual visits use live two-way video. **Audio-only visits** are by telephone without video, when appropriate and permitted; they carry additional limitations and coverage varies by plan.

BEFORE EACH VISIT

At the start of every visit we confirm your identity and ask where you are physically located — so we can send emergency services if needed and confirm we may treat you there. Dr. Hayton will state his name, credentials, location, license number, and a practice phone number.

BENEFITS, LIMITATIONS & RISKS

- Benefits: no travel time or cost, less exposure to illness, convenient follow-up and routine care.
- Dr. Hayton cannot perform a hands-on examination by telehealth, so findings may be missed, a diagnosis delayed or incorrect, and in-person evaluation may still be needed.
- Information may be lost or distorted by technical problems, and some conditions require an in-person visit. Telehealth suits established patients best; new-patient exams and visits needing labs are generally done in person.
- Dr. Hayton is licensed in Idaho. If you are outside Idaho at the time of a visit, tell us — we may need to reschedule until you return.

IF THE CONNECTION FAILS, OR YOU HAVE AN EMERGENCY

If we lose audio or video, Dr. Hayton will call the phone number on file to finish or reschedule. **Telehealth is not for emergencies — call 911 or go to the nearest emergency room.** Your provider may not be able to reach emergency services for you, which is why we confirm your address at each visit.

PRIVACY & SECURITY

Our telehealth technology supports HIPAA-required safeguards including encryption in transit, but no electronic communication is completely secure and an ordinary telephone call is not encrypted. We will not record your visit without your separate, explicit consent. Use a private location and a secure connection; people nearby may overhear. Dr. Hayton will tell you if another staff member is present.

CONTROLLED SUBSTANCES

Federal and state rules on prescribing controlled substances by telehealth change from time to time. Dr. Hayton follows the requirements in effect at the time of your visit and will tell you if an in-person exam is needed first. Whether a controlled substance is appropriate for you is always a separate clinical decision.

COST

Telehealth visits are generally billed like in-person visits and your cost-sharing applies the same way, but coverage rules differ by plan and can change. If an in-person visit is also needed you may owe for both. Ask your insurer about coverage.

YOUR RIGHTS

- You may choose an in-person visit instead at any time, and may stop a telehealth visit at any point. Dr. Hayton may also determine that a concern needs an in-person visit.
- You may withdraw this consent at any time in person, by phone, or in writing; withdrawing will not affect your right to in-person care. Until then it stays in effect, and each telehealth visit is documented in your medical record.

By signing below, I confirm I have read and understand this information, my questions have been answered, and I voluntarily consent to receive care by telehealth.

SIGNATURE

SIGNATURE OF PATIENT OR REPRESENTATIVE | PRINTED NAME | IF REPRESENTATIVE: RELATIONSHIP & AUTHORITY | DATE

Authorization to Release Medical Records

Use this form to have a prior provider send your records to Hayton Primary Care.

PATIENT

LAST NAME | FIRST NAME | DATE OF BIRTH

FORMER NAME(S), IF ANY | PHONE | ADDRESS | CITY / STATE / ZIP

I AUTHORIZE THE FOLLOWING PROVIDER TO RELEASE MY RECORDS

PROVIDER OR FACILITY NAME | PHONE | FAX

ADDRESS | CITY / STATE / ZIP

TO BE SENT TO

Hayton Primary Care / HPC Medical Group PLLC · 300 W. Main St., Suite 100, Boise, ID 83702 · Phone (208) 247-4279 · Fax 208-684-2455 · info@haytonprimarycare.com

RECORDS REQUESTED

DATES OF SERVICE — FROM | TO

- ☐ Complete record
- ☐ Office visit notes / H&P
- ☐ Consultation notes
- ☐ Operative reports
- ☐ Lab / pathology
- ☐ Imaging reports
- ☐ Immunizations
- ☐ Discharge summaries

Sensitive records — released only if checked:

- ☐ Alcohol / substance use disorder
- ☐ Mental / behavioral health
- ☐ HIV / AIDS / STI
- ☐ Genetic testing or counseling

Purpose: At my request, for continuity of my medical care. **Expiration:** One (1) year from the date I sign, unless I write an earlier date or event here: _____

PLEASE READ BEFORE SIGNING

- **You may revoke this authorization at any time.** Send a signed written statement to Hayton Primary Care at the address above, or to the releasing provider. It takes effect when received and does not undo a release already made in reliance on it.
- **This authorization is voluntary.** Hayton Primary Care will not condition your treatment, payment, or eligibility for benefits on whether you sign.
- **Redisclosure.** Information released may be redisclosed by the recipient and may then no longer be protected by the federal privacy rules at 45 C.F.R. Parts 160 and 164.
- **Substance use disorder records.** If any records released are protected by 42 C.F.R. Part 2, federal law prohibits the recipient from further disclosure except as expressly permitted by written consent or otherwise permitted by Part 2. A general authorization for release of medical information is NOT sufficient. Federal rules restrict use of these records to criminally investigate or prosecute a patient with a substance use disorder.
- **You will receive a copy of this signed authorization.** A photocopy, fax, or electronic image of this authorization is as valid as the original.

SIGNATURE

PATIENT SIGNATURE | PRINTED NAME | DATE

If signed by the patient's personal representative (legal guardian or agent under a health care power of attorney):

SIGNATURE OF REPRESENTATIVE | PRINTED NAME | RELATIONSHIP & LEGAL AUTHORITY | DATE

Representative's authority: legal guardian · agent under health care power of attorney · executor · other: _____

OFFICE USE ONLY — Copy of signed authorization provided to patient: ☐ Yes Date: _____ Staff initials: _____

Nondiscrimination & Language Assistance

NOTICE OF NONDISCRIMINATION

Hayton Primary Care / HPC Medical Group PLLC complies with applicable federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

We provide, free of charge:

- aids and services to help people with disabilities communicate effectively with us — including qualified sign language interpreters and written information in other formats such as large print, audio, and accessible electronic formats; and
- language services to people whose primary language is not English — including qualified interpreters and information written in other languages.

To request an interpreter, a document in another format, or any other accommodation, call **(208) 247-4279** or ask any staff member. There is never a charge for these services.

HOW TO FILE A GRIEVANCE OR COMPLAINT

If you believe we have failed to provide these services or have discriminated in any way, you may file a grievance with our Privacy Officer:

Privacy Officer, Hayton Primary Care
300 W. Main St., Suite 100 · Boise, ID 83702
Phone (208) 247-4279 · Fax 208-684-2455 · info@haytonprimarycare.com

You may file in person, by mail, by fax, or by email. If you need help filing a grievance, our Privacy Officer will assist you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- Online at ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail to U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, D.C. 20201
- By phone at 1-800-368-1019 (TDD 1-800-537-7697)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

TO BE COMPLETED BEFORE PUBLICATION — Insert the "Notice of Availability of Language Assistance Services and Auxiliary Aids and Services" taglines here, in English plus the fifteen (15) languages most commonly spoken by individuals with limited English proficiency in Idaho. HHS publishes translated sample taglines. This notice must also appear on the practice website and be provided annually.