NORTH IDAHO MEMORY CLINIC

John A. Wolfe, PhD
2190 Ironwood Center Dr. Ste 2
Coeur d'Alene, ID 83814
(208) 666-0357

Susan Melchiore, MD
On Site for Seniors, Inc
PO Box 238
Hayden, ID 83835
(208) 967-4771

Brenda L. Roberts, LCSW
505 N Argonne, Suite B108
Spokane Valley, WA 99212
(509) 926-9911

Welcome to North Idaho Memory Clinic

We are privileged to be able to partner with you to meet memory needs. The North Idaho Memory Clinic (NIMC) is a multi-disciplinary approach to diagnosing and managing memory problems. The first step is to confirm that the patient will be helped by going through NIMC by completing the attached questionnaire. Once we receive the completed paperwork, Dr. Melchiore and Dr. Wolfe and Brenda Roberts will have their individual office staff phone the patient to schedule visits. North Idaho Memory Clinic accepts Medicare, Medicaid and most other major insurances.

Enclosed is a packet that needs to be completed before your first appointment can be scheduled. Please fill out each page completely and return it to our office via mail, **WITH the following:**

- ✓ **Copies of all insurance cards, front and back (including prescription cards)**
- ✓ **Copy of Power of Attorney (if it exists)**
- ✓ **Copy of Living Will and/or POST Form (if it exists)**
- ✓ **Copy of Identification Picture or a small photo**
- ✓ **Signature at bottom of enclosed "Patient Information" sheet (required)**

Return paperwork to the following address:
2190 Ironwood Center Dr. Ste 2
Coeur d'Alene, ID 83814
Fax: (208)666-0468

****Paperwork needs to be returned to North Idaho Memory Clinic within 60 days, or it will be assumed that you have decided not to pursue consultation through the North Idaho Memory Clinic.***

If you have any questions, please do not hesitate to call our office at (208) 666-0357.

Thank you

NORTH IDAHO MEMORY CLINIC

John A. Wolfe, PhD	Susan Melchiore, MD On Site for Seniors, Inc	Brenda L. Roberts, LCSW
2190 Ironwood Center Dr. Ste 2 Coeur d'Alene, ID 83814 **(208) 666-0357**	PO Box 238 Hayden, ID 83835 **(208) 967-4771**	505 N Argonne, Suite B108 Spokane Valley, WA 99212 **(509) 926-9911**

Appointments and cancellations:

North Idaho Memory Clinic patients are seen at 2190 Ironwood Center Dr. Ste 2, Coeur d'Alene, ID.

If you are unable to attend a scheduled appointment, please call our office at least **24 hours** prior to your appointment time.

Refill Policy (Don't wait until you run out of your medicine!):

It is the general policy of On Site for Seniors, Inc. to request that you **contact your pharmacy at least 3 business days before you run out of your medication to obtain refill** authorization. Many of the prescription insurance plans have to be completed, often causing delays in processing. For this reason, we request that you contact your pharmacy at least 3 business days before you run out of your medication to request refills.

Cost of Services:

We are **Medicare participating** providers and most other major insurances. We also accept Medicaid reimbursement for medical services only. You are responsible to pay for all services rendered to you at the NIMC. These services will be billed by the providers' individual private practices: On Site for Seniors, Inc., John A. Wolfe, PhD, LLC and Associates and Brenda L. Roberts, LCSW.

NORTH IDAHO MEMORY CLINIC

JOHN A. WOLFE, PhD *SUSAN MELCHIORE, MD* *BRENDA L. ROBERTS, LCSW*
ON SITE FOR SENIORS, INC

Today's Date:_____ *** PATIENT/RESPONSIBLE PARTY INFORMATION ***

Patient Name: _____ Sex: _____ Date of Birth: _____

Social Security #: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Physical Address: _____ City/State: _____ Zip: _____

Mailing Address: _____ City/State: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Contact Person _____ Relationship _____ Phone _____

*** RESPONSIBLE PARTY, PARENT, POA, or GUARDIAN ***

Name: _____ Relationship: _____

Address: _____ Phone _____

*** INSURANCE INFORMATION (Primary) ***

Insurance Co: _____ Insurance Co. Phone: ( ) _____

Policy Holder: _____ Date of Birth: _____

ID/Policy #: _____ Group #: _____ Effective Date: _____

*** INSURANCE INFORMATION (Secondary) ***

Insurance Co: _____ Insurance Co. Phone: ( ) _____

Policy Holder: _____ Date of Birth: _____

ID/Policy #: _____ Group #: _____ Effective Date: _____

Who Referred You To Us? _____

To the best of my knowledge, all of this information is true and complete. I understand that I am responsible to pay for all services rendered to me at the NORTH IDAHO MEMORY CLINIC and that I am willing to make specific arrangements to pay whatever part that is not covered by insurance on a timely basis. **(PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE PROVIDER AND IS NOT A SUBSTITUTE FOR PAYMENT.)**
I grant permission to my physician to mutually exchange medical information with my referring physician(s) and/or their associates. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record to my insurance carrier or Medigap carrier.

I have the right to revoke (cancel) my authorization for provider to release information about me and my health to government programs and insurance company(s). My revocation must be in writing. It will not be effective until received by provider. If my revocation results in denial of payment, I am responsible to for the care provider.

If this account is assigned to an attorney for collections and/or suit, the prevailing party(s) shall be entitled to reasonable attorney's fees and costs of collection. I HERBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO MY PORVIDERS at MEMORY CLINIC FOR SERVICES RENDERED TO ME. Theses services will be billed by the providers' individual private practices: On Site for Seniors, Inc., John Wolfe, PhD LLC and Associates and Brenda L. Roberts, LCSW. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

SIGNATURE (Responsible Party): _____ Date: _____

If signing on the behalf of the patient: Printed Name_____Relationship_____

MEDICARE ASSIGNMENT/SIGNATURE ON FILE:
I request that payment of authorized Medicare benefits be made on my behalf directly to On Site for Seniors, Inc., John Wolfe, PhD LLC and Associates and Brenda L. Roberts, LCSW, for any service furnished me by the physicians/providers. I authorize all of the above practices named to release information to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits or the benefits payable for related services.

SIGNATURE: _____ Date: _____

MEDICARE/MEDICAID Advanced Beneficiary Notice *(Brenda Roberts, LSCW only)*
Although I am a contracted provider with Medicare ***(I am not contracted with some Medicare Advantage Plans in Idaho)*** and Molina, I am **not** a contracted provider with Idaho State Department of Health and Welfare or with the Washington State Department of Social and Health Services (DSHS, also known as Provider One in Washington State). Medicaid will not pay for any services provided by a non-contracted provider. Medicaid will not be billed by my office whether it is your primary insurance or your secondary coverage.
I have read, understand and agree to the above Medicare/Medicaid Advanced Beneficiary Notice with regards to my Medicaid insurance. I agree to be personally and fully responsible for payment.

SIGNED: _____ Date: _____

NORTH IDAHO MEMORY CLINIC

JOHN A. WOLFE, PhD *SUSAN MELCHIORE, MD* *BRENDA L. ROBERTS, LCSW*
ON SITE FOR SENIORS, INC

Patient Name _____ Date of Birth _____

PATIENT COMMUNICATION CONSENT FORM

I agree to allow *On Site For Seniors, Inc, John A. Wolfe, Ph.D., LLC and Associates and Brenda L. Roberts, LCSW* to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize *On Site For Seniors, Inc, John A. Wolfe, Ph.D., LLC and Associates and Brenda L. Roberts, LCSW* to leave messages for me when I am unavailable.

METHOD	NUMBER/ADDRESS	OK TO LEAVE A MESSAGE?
____Home Phone	(____) _____	☐ No ☐ Yes
____Cell Phone	(____) _____	☐ No ☐ Yes
____Work Phone	(____) _____	☐ No ☐ Yes
____Alternate phone	(____)_____	☐ No ☐ Yes
____E-mail or text *(Brenda Roberts Only)* _____		☐ No ☐ Yes
____Patient Portal *(On Site for Seniors & Brenda Roberts Only)*		☐ No ☐ Yes

I authorize *On Site For Seniors, Inc, John A. Wolfe, Ph.D., LLC and Associates and Brenda L. Roberts, LCSW* and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving spaces blank I am indicating my choice to authorize "No Information" and I do not want any information released to anyone else.

NAME	RELATIONSHIP TO PATIENT	CONTACT INFO

EMERGENCY CONTACT ONLY (No private health information will be communicated)

NAME: _____ Phone: _____

GUIDELINES REGARDING PATIENT COMMUNICATION

The doctors, and others here at On Site For Seniors, Inc, John A. Wolfe, Ph.D., LLC & Associates and Brenda L. Roberts, LCSW want to do all we can to protect the health information we have about your and keep it private and secure. You have a right to that information and the right to talk, e-mail, or text your health care team about it. But, any time you talk, e-mail, or text there is a chance that someone you do not want to can hear or see what you say or write. Below is a list of some things that you and we can do to reduce those chances when we talk, e-mail or text.

Phone Calls

A. When we need to contact you, we will only speak to you or people you have listed on the Communication form.
B. On the Communication consent form you should list only the numbers you wish us to use to contact you.
C. If you are unable to answer our call, please check "yes" in the box under Messages if you want us to leave a message with the person who answers. If you do not want a message left please check "no".

Emergency Contact

A. An Emergency Contact is a person you chose for us to call if we cannot reach you. An emergency message is when there is a real danger to you or someone else.

By my signature below I acknowledge that I have read and understand the **Guidelines to Patient Communication** and information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions, restrictions and patient responsibilities outlined within the Guidelines as well as any other instruction that *On Site For Seniors, Inc, John A. Wolfe, Ph.D., LLC and Associates and Brenda L. Roberts, LCSW* may impose.

_____

Patient Name printed **Date**

_____

Patient/Authorized signature **Relationship to patient**

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AUTHORIZATION FOR NORTH IDAHO MEMORY CLINIC, TO OBTAIN, USE OR DISCLOSE MY HEALTH INFORMATION

Patient name: _____ Date of birth: _____
Previous name: _____ SSN: _____

I. My Authorization: By initialing the spaces below, I specifically authorize the use or disclose the following health care information and/or records (initial all that apply):

____ All my health information ____Laboratory and/or Pathology Reports Only ____Most recent 2 year history
____My health information for the date(s): _____ ____ Medication List
____My health information relating to the following treatment or condition: _____
____Other: _____

The following items must be initialed to be included in the use or disclosure of other health information:

_____HIV/AIDS related health information and/or records _____Sexually Transmitted Disease Information and/or records
_____Mental Health Information and/or records _____ Genetic testing information and/or records
_____Drug/Alcohol diagnosis, treatment and/or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

You may __Disclose, __Obtain and Use, and/or __Exchange this health information to/from: CHECK ALL THAT APPLY

Name (or title) and organization_____
Address: _____City _____State _____Zip_____
Phone #:_____ May we transmit your records via fax? __Yes __No Fax #:_____

Reason(s) for this authorization (check all that apply):

☐ at my request ☐ other (specify) _____

This authorization ends: ☐ on (date) _____ ☐ No Date Restrictions

Or ☐ when the following event occurs _____

II. My Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by **North Idaho Memory Clinic** based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The way to revoke this authorization is:

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc)

_____
Witness

FOR OFFICE USE ONLY:
DATE RECEIVED: _____ PROVIDER APPROVED_____OR PROVIDER DENIED_____ (Initial & Date)
IF DENIED, REASON: _____
HEALTH INFORMATION SENT: _____
SENT VIA MAIL/FAX/OTHER: _____ DATE PROCESSED: _____ROCESSED BY STAFF: _____

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CONSENT TO TREATMENT / ACKNOWLEGEMENT OF PRIVACY PRACTICES

Please read the following information below. Initial each statement that applies. Your signature below applies to the service rendered in conjunction with all of your visits at North Idaho Memory Clinic.

Patient Name: _____DOB: _____

Consent of Treatment

_____(Patient Initials) I, the undersigned, consent to outpatient care at North Idaho Memory Clinic, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to: routine laboratory work (such as blood, urine, and other studies), heart racing and administration of medications prescribed by the provider. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff including physicians, nurse practitioners, physician's assistants, medical assistants or their designees as is necessary in the medical staff's judgment. I authorize North Idaho Memory Clinic to release any information necessary to file and settle insurance claims, including any third party insurances. I understand I am personally financially responsible to North Idaho Memory Clinic for all changes not covered by assignment including co-pays, co-insurance and ineligibility.

Patient Rights and Responsibilities

_____ (Patient Initials) I, the undersigned, have received the Patient Rights and Responsibilities form. I understand and agree to abide by the conditions for treatment at North Idaho Memory Clinic.

Acknowledgement of Privacy Practices

_____ (Patient Initials) I, the undersigned, understand that under the Health Insurance Portability & Accountability Act of 1996 ("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 the *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 Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our 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.

Signature: _____ Date: _____

If the patient is a minor or is unable to consent please complete the following

Printed Name of Signee: _____

Relationship of Person authorized to consent for patient: _____

Patient Portal Authorization Form for On Site for Seniors, Inc.
(*required information)

*Print Patient Name and Birthdate: _____

*Responsible Party/Legal Guardian: _____ ***Phone:**_____

***Personal Email Address (please print clearly):** _____
(Please supply the ***personal email address and photo ID of the person who will be using the patient portal)***

Purpose of this Form:
The patient portal offers patients of On Site for Seniors, Inc. (OSFS) a secure way to view parts of their healthcare records. Please read this form thoroughly before signing to request access to view your medical records on the patient portal.

How the Patient Portal Works:
A secure web portal is a kind of web page that uses computer security to keep unauthorized persons from reading information or attachments. Health information can only be read by someone who knows the right password to log into the portal site. Once you are logged into the portal, you will have access to only your records or those for whom you are legally responsible.

The patient portal will allow you to:

- View our contact information and office hours and in the upper right-hand corner you may select "Send Message" (this allows you to send a separate message to On Site for Seniors), "My Profile" or Sign Out
- Under the "Messages" tab you can select to read items in your Inbox, Sent File and delete messages or Send Message
- In the Inbox, you may choose to reply, forward, print or open the message as a PDF document
- Print or save an electronic copy of the health summary using the continuity of care document format.

How to Participate in the Patient Portal:
Upon receipt of your photo ID and this completed form, your email address will be entered into your record. Your provider will upload your health summary to the portal and you will receive an invitation to your personal e-mail to set up your user name and password for the patient portal.

Protecting Your Private Health Information and Risks:
This method of communicating and viewing prevents unauthorized parties from being able to access your private health information. However, keeping health information secure depends on two important factors; we need you to make sure we have your correct email address and you must inform us if it ever changes. We strongly suggest that you use a personal email account rather than a work email address as this information might be available to your employer. You need to keep unauthorized persons from learning your password. If you think someone has learned your password, you should promptly change it via the patient portal.

Conditions of Participating in the Patient Portal:
We understand the importance of privacy with regard to your health care and will continue to protect the privacy of your medical information. Our use and disclosure of medical information is described in our Notice of Privacy Practices. Access to this secure web portal is an *optional service*, and we may suspend or discontinue it at any time for any reason. If we do, we will notify you as promptly as possible. As a user of the patient portal and by signing this form you agree NOT to:

1) Transmit any electronic information that violates the rights or privacy of any party.
2) Use the Web portal in any way that would violate local, state or federal laws.
3) Transmit materials that are obscene, defamatory, abusive, slanderous or otherwise likely to result in harm to others.
4) Intentionally destribute software/computer viruses or take any other action that could compromise the security of our computer system.

Patient/Responsible Party/Legal Guardian Acknowledgement:

Signature: _____ **Date:** _____

Please send or fax this form and a copy of a photo ID to the Medical Record Department at:
On Site for Seniors, Inc., PO Box 238, Hayden, ID 83835, FAX: 208-683-8101
Questions? Call 208-967-4771

North Idaho Memory Clinic Questionnaire

Confidential Health Care Document

Thank you for completing this form before your visit. It will allow your doctor to perform the most thorough evaluation possible when you arrive for your appointment.

Name: _____ **Date of Birth**: _____

Address: _____ **Phone**: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Living with significant other

Contact Person (if other than patient): _____

Relationship: _____ **Phone**: _____

Form completed by: ☐ Self ☐ Other (please give name below) Date completed: _____

Name: _____ **Relationship**: _____

* **Who is your primary physician**? _____ **Date last seen**: _____

* **Do you see other physicians**? ☐ Yes ☐ No If yes, please list: _____

_____

* **Do you live**: (check all that apply)
☐ by yourself ☐ with spouse ☐ with caretaker ☐ in senior housing/retirement center
☐ with other family members, who? _____ ☐ other? _____

* **How many children do you have**? _____ **Are you in regular contact with them** ☐ Yes ☐ No

* **How much school did you complete**? ☐ Less than 8th grade ☐ Some high school
☐ High school graduate ☐ Some college ☐ College graduate ☐ Graduate school

* **Current work status**: ☐ Retired/not working ☐ Working part-time ☐ Working full-time
* **Previous occupation**(s): _____

* **Do you employ someone to provide health-related care or help you in your home**? ☐ Yes ☐ No
If yes, hours per day: _____ days per week: _____ Does this meet your needs? ☐ Yes ☐ No

* **Do you provide care for a family member**? ☐ Yes ☐ No

* **How would you describe your health**? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

* **Are you able to do the things you want to do**? ☐ Not at all ☐ Some things ☐ Most all things

* **Do you currently participate in any regular physical activity**? ☐ Yes ☐ No If yes, how often? _____
☐ Aerobics or exercise classes ☐ Bicycling or stationary bike ☐ Dancing ☐ Walking ☐ Jogging
☐ Swimming ☐ Tennis ☐ Golf ☐ Bowling ☐ Yoga ☐ Pilates ☐ Other _____

* **When did you first notice memory problems**? _____

_____

* **What do you hope to gain from your visit to the North Idaho Memory Clinic**? _____

_____

_____

_____

North Idaho Memory Clinic Questionnaire

Confidential Health Care Document

* **During the last year have you**:

Been hospitalized? ☐ Yes ☐ No If yes, where? _____

Been in the emergency room? ☐ Yes ☐ No

Have you had a death of a spouse or close family member, friend or pet? ☐ Yes ☐ No

Have you moved (in the past year)? ☐ Yes ☐ No

* **Do you experience any of the following** (check all that apply)?

☐ Depression ☐ Anxiety ☐ Feelings of sadness ☐ Feel anxious about memory loss

* **Do you drive**? ☐ Yes ☐ No **Do you always wear a seatbelt when you ride in a car**? ☐ Yes ☐ No

* **Do you smoke**? ☐ Yes ☐ No **Did you ever smoke**? ☐ Yes ☐ No

How much? (average per day): _____

* **Do you drink alcohol**? ☐ Yes ☐ No

What type? ☐ Beer ☐ Wine ☐ Liquor How much? (average per day): _____

* **Do you have an Advance Directive or Living Will document for health care preferen**☐? Ye☐ No

If not, would you like information? ☐ Yes ☐ No

* **Are you currently using any services from the community**?

☐ Home Healthcare ☐ Transportation ☐ Meals on wheels ☐ Other _____

* **What family, friends or neighbors are helpful to you**?

Name: _____ Phone: _____

Name: _____ Phone: _____

* **Have you had any of the following conditions**? (If yes, when) ☐ Diabetes ____ ☐ Depression ____

☐ Dementia or Alzheimer's disease ____ ☐ Heart disease ____ ☐ Stroke ____

☐ Cancer: ☐ Breast ____ ☐ Prostate ____ ☐ Lung ____ ☐ Colon/rectum ____

☐ Skin ____ ☐ Lymphatic ____

☐ Other (specify): _____

* **Have any members of your family had any of the following conditions**?

☐ Diabetes ☐ Depression ☐ Dementia or Alzheimer's disease ☐ Heart disease ☐ Stroke

☐ Cancer: ☐ Breast ☐ Prostate ☐ Lung ☐ Colon/rectum ☐ Ski☐ Lymphatic

☐ Other (specify): _____

Past medical /surgical history	Year

North Idaho Memory Clinic Questionnaire

Confidential Health Care Document

*** List all medications that you take. Please include all prescription med, non-prescription supplements, and natural products.**

Current Medication Example: Aspirin	Strength of tablet/capsule Example: 81mg	How do you take it? Example: 1 pill daily

*** Do you have any drug allergies?** ☐ Yes ☐ No If yes, please list drug and check reaction to drug

Name of drug	Rash	Shortness of breath	Nausea	Other (specify)

*** At this time do you have difficulties in any of the following areas?**

	Yes	No	At times		Yes	No	At times
Sleeping				Appetite			
Memory				Swallowing			
Concentration				Dizziness			
Fatigue				Pain			
Hearing				Communicating your needs			
Falling				Remembering appointment or dates			
Vision				Getting lost			
Walking				Forgetting family names			

North Idaho Memory Clinic Questionnaire

Confidential Health Care Document

*** At this time do you have difficulty with any of the following activities?**

Task	Completely unable to perform task	Requires Assistance to perform task	Can perform task but with difficulty	No problems performing task
Feeding yourself				
Dressing				
Going to the bathroom				
Bathing or showering				
Getting in/out of the tub or shower				
Grooming				
Getting from bed to chair				
Walking across the room				
Climbing a flight of stairs				
Using the telephone				
Heating water, operating stove				
Preparing a balanced meal				
Following dietary restrictions				
Doing laundry				
Doing housework				
Shopping alone for household goods/clothes/groceries				
Writing checks, paying bills, balancing checkbook				
Assembling tax records, business affairs				
Taking medications				
Remembering appointments, family events				
Playing a game of skill or hobby				
Keeping track of current events				
Paying attention to a TV show or reading material				
Traveling out of the neighborhood alone (driving or arranging transportation)				