



Welcome to OnePeak Medical Group. Thank you for choosing us for your care. Our mission is to provide the highest quality care that is convenient and comprehensive to our patients. In effort to reduce confusion between our patients and the practice we have adopted the following policies for our office

Please read its entirety

- For Prescription Refills, please contact your pharmacy and have them send a refill request.
- We are required by law to collect your copays, deductibles, and co-insurance in a timely matter. Please assist us with this by having your payment ready at time of service.
- No child Under the age of 18 may be left unattended anywhere in our facility.
- Please call us and let us know if you are unable to make it to your appointment at least 24 hours in advance. If you “No Show” for your appointment three times, we will discontinue care for you at our facility. In addition, if you do not show up for your appointment or if you do not cancel your scheduled appointment at least 24 hours prior to your scheduled time, you will be charged a fee of \$40.00

All account balances are due within 30 days of receiving a statement. Any Account with an outstanding balance after 90 days will be transferred to an outside collection agency. *Please note at the time your account is transferred your account will be charged 25% of the remaining balance and **\$25.00 transfer fee** and the collection agency may have additional fees if not promptly paid.* It is very important to keep us informed if you are on a payment arrangement and are going to miss a payment to avoid these additional fees. Also, if your account is transferred to an outside collection agency, we will no longer be able to see you until your account is paid in full. We will finance any acceptable payment arrangement that meets our policy criteria, with finance charge of 5% per month

Please also be aware, that anytime there is a lab drawn or specimen taken from you (biopsy, blood, swabs, Pap smear, excision, etc...) it will be sent to an outside lab. You will receive a bill from that lab in addition to our charges. Please ask if you have any concerns regarding which lab will be used for you and/or lab charges.

Please do not hesitate to contact us if you have additional questions

Patient _____
Date: _____

Signature: _____

Patient Intake Form

FULL LEGAL NAME: _____

Date of Birth: _____ **SSN:** _____ **Gender:** _____

Mailing Address: _____ **APT No:** _____

City: _____ **State:** _____ **ZIP Code:** _____ **County:** _____

Marital Status: M S D W Partner

Home phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Preferred Method of Contact: Circle Phone Text Email(Portal)

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Primary Care Provider: _____ **Referring Provider:** _____

Pharmacy: _____ **Location:** _____ **City/State:** _____

RESPONSIBLE PARTY

(Please be aware if you are over 18 years of age you are the responsible party)

Person Responsible: _____ **Relationship:** _____

Date of Birth: _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy ID:** _____

Group No: _____ **Policy holder:** _____

Policy Holder Date of Birth: _____ **SSN:** _____

Phone: _____ **Address of Policy Holder:** _____

Is this your only insurance YES / NO _____ **City, ST, ZIP:** _____

By Signing Here, I agree that I am financially responsible for this account, and I give consent for care/treatments to OnePeak Medical Care for Women.

Signature _____

HISTORY

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

Today's Date: _____ **Nickname:** _____

Age: _____ **Marital Status:** M S D W Partner

Current Medications/Supplements/Vitamins with Dosage		Patient History:	YES	NO	Comments:
		Breast Cancer			
		Colon Cancer			
		Other Cancer, please list			
		High Blood Pressure			
		Elevated Cholesterol			
		Heart Attack			
		Heart Murmur			
		Stroke			
		Clotting Disorder			
		Anemia			
		Diabetes			
		Emphysema			
		Chronic Bronchitis			
		Ulcers			
		Colitis			
		Colon Polyps			
		Gallstone			
		Liver Disease			
		Arthritis			
		Autoimmune Disorder			
Surgeries/Procedures	Year	Migraine Headaches			
		Multiple Sclerosis			
		Seizures			
		Glaucoma			
		Stress/anxiety (circle)			
		Depression			Treatment?
Other Hospitalizations	Hospital	Date	Chemical Dependency		
			Endometriosis		
			Chronic Pelvic Pain		
			Abnormal Pap (History)		
			Urinary Tract Infections		
			Urinary Incontinence		
Drug Allergies/Sensitivities	Reaction		Osteoporosis		
			PCOS		
			History of Prolapse		
			IBS		

		Other:
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Pregnancies-

How many children	Vaginal	Cesarean	Miscarriage	Gest. Age Weeks	Male	Female	Weight/Complications

Menstrual History

When was the first day of your last period?	Menopausal Symptoms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Typical # days of flow	Post- Menopausal Symptoms	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Typical Number days from 1 st day of period to 1 st day of next period?	If post-menopausal, month/ year of last period?		
Amount of Flow?	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Mod <input type="checkbox"/> Severe
Menstrual Cramps	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Mod <input type="checkbox"/> Severe
Symptoms of PMS	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Mod <input type="checkbox"/> Severe
Bleeding between Periods	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Mod <input type="checkbox"/> Severe

Current Method of Contraception? _____

History of STD's? _____

Have you been sexually active in the last 12 months? _____

Health Maintenance Screening Tests

	Date	Result		Date	Result
Mammogram			Stool Blood		
Lipid Screen			Colonoscopy		
PAP Smear			Bone Density		

Family History

Is there a family history of ...	YES	NO	Relationship (Father, Mother, Brother, Maternal Grandma, Paternal Grandpa, etc.)	Living	Deceased	Age Deceased
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other Cancer, Type?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune Disorders	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Other Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Psychiatric	Negative	Anxiety Feeling Sad	Thoughts of suicide Can't Concentrate	Hallucinating Hearing Voices
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Patient Name: _____ **Date of Birth:** _____

PATIENT REGISTRATION AND CONSENT FOR TREATMENT

1. CONSENT FOR TREATMENT. I voluntarily consent to inpatient and/or outpatient care and treatment performed by my physician and all other health care providers at OnePeak Medical Care. I also consent to routine services, diagnostic procedures, medical treatment, other health care services deemed necessary by the health care providers treating me. I understand that the practice of medicine and surgery is not an exact science, and that diagnosis and treatment may cause injury or even death. I understand that I have a right to consent or to refuse to consent to any proposed surgery, procedure, or treatment, and to discuss it with my health care provider. I also understand that during my medical treatment I may have one or more photographs of my skin or wound(s) taken, to use in monitoring my treatment and guiding healthcare provider interventions. I understand that individuals who want to learn about the roles of healthcare providers may observe the treatment I receive, and I consent to this, but I have the right at any time to object to letting such an individual observe and my objection will be honored. If this Patient Registration and Consent for Treatment is signed as part of an Emergency Department or other outpatient visit, it will continue for any related inpatient admission.

2. AUTHORIZATION, FOR RELEASE OF INFORMATION. I authorize OnePeak Medical Care and its health care delivery sites to utilize confidential medical/Surgical or other information contained in my medical record as necessary for claims payment, medical management, or quality of care review purposes. I further authorize the release and discharge of such confidential, information to my insurance company or other health coverage plan, including government payers, as necessary for claims payment, medical management and quality review activities conducted by such company or plan, or its designees. This authorization includes the release of an acquired immunodeficiency syndrome (AIDS) diagnosis or a positive Human Immunodeficiency Virus (HIV) antibody test result, alcohol and/or drug abuse information, genetic testing, congenital disorders, and mental health information. I understand this authorization for release of information can be revoked by me in writing at any time, but only with respect to the proposed treatment and not with respect to care and treatment that has already been rendered to me.

3. WAIVER OF RESPONSIBILITY FOR PERSONAL VALUABLES. I understand that Onepeak Medical Care, or any of its health care delivery sites do not assume any responsibility for the loss or damage to my personal property.

4. PAYMENT AGREEMENT AND ASSIGNMENT. Except as prohibited by any agreement between my insurance company and OnePeak Medical Care, or by state or federal law, I agree to be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third-party payers. I authorize OnePeak Medical Care to file any claims for payment of any portion of the patient bills and assign all rights and benefits to OnePeak Medical Care as appropriate. I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses and interest in the event OnePeak Medical Care take action to collect same because of my failure to pay in full all incurred charges.

**I have read this form, and by signing this form I understand and agree to what it says.
The consent for treatment shall be effective for (1) year.**

Signature: _____

DATE: _____

Patient Signature Date (Or parent/guardian/other authorized person if Patient is a minor, mentally incompetent, _____ physically unable to sign this form)
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Witness to Signature

Printed name of authorized Signature: _____

Reason person is unable to sign: _____

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

Dear Patient,

Payment is required at time of service.

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provisions that have been agreed between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balance could jeopardize our contract with your carrier. If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out-of-pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that any have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payments, or deductible under the terms of the anti-kickback laws.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance, we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Thank you for your understanding in the matter.

X

Responsible Party Signature

How did you hear about us? _____

HIPAA Notice of Privacy Practices - (45 C.F.R. § 164.520)

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. If you have any questions about this notice, please contact our privacy officer at OnePeak Medical

OUR OBLIGATIONS: We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer. For Treatment.

1. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
2. For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.
3. For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses, and disclosures are necessary to make sure that all our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality.
4. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities. Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.
5. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.
6. Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
7. Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
8. SPECIAL SITUATIONS: As Required by Law. We will disclose Health Information when required to do so by international, federal, state, or local law. To Avert a Serious Threat to Health or Safety.

9. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.
 10. Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
 11. Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.
 12. Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
 13. Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
 14. Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
 15. Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
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16. Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
 17. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
 18. Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
 19. Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
 20. National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
 21. Protective Services for the President and Others. We may disclose Health Information to authorize federal officials, so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.
 22. Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution. USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT
 23. Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
 24. Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked It will not be affected by the revocation.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you: Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to OnePeak Medical Care , 1003 North Orchard St Boise Idaho . We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you reasonable. Cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information, we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to OnePeak Medical Care 1003 N. Orchard Boise Idaho 83706

You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to OnePeak Medical Care 1003 N. Orchard Boise Idaho 83706

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to OnePeak Medical Care 1003 N. Orchard Boise Idaho 83706. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to OnePeak Medical Care 1003 N. Orchard Boise Idaho 83706. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, you must make your request, in writing, to OnePeak Medical Care 1003 N. Orchard Boise Idaho 83706 **CHANGES TO THIS NOTICE:** We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner. **COMPLAINTS:** If you believe your privacy rights have been violated. You may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Practice Manager at OnePeak Medical Care 1003 N. Orchard Boise Idaho 83706

You may designate two people to whom we may discuss your condition and treatment:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

By Signing Here, I acknowledge that I have read and understand the Privacy Practices for OnePeak Medical Care . I am also aware that if I listed anyone above they will be able to receive any of the information discussed with this office regarding my health care. I understand that I can revoke this authorization anytime in writing to OnePeak Medical Care

Signature _____ Date: _____

Patient's Name: _____ Date of Birth: _____

Email Address: _____

For questions regarding your bill from OnePeak Medical Care please call 208-331-6700.

For questions regarding your bill from Lab Corp please call 1-800-845-6167.

For questions regarding your bill from St. Luke's please call 208-381-2222 and ask for their billing department.

For questions regarding your bill from St. Alphonsus please call 208-367-2121 and ask to speak with their billing department.

I agree and give permission for OnePeak Medical Care to send my summary of services to the above listed email address. I understand that I may reach out at anytime with any questions or concerns. However, if I disagree with the summary of services, I agree to reach out within 7 business days.

Patient Signature

Date