PATIENT REGISTRATION FORM

Full Circle Health is a Federally Qualified Health Center and receives federal funding pursuant to Section 330 of the Public Health Service Act. We are required to collect information about age, gender, race, sexual orientation, income, and family size for statistical purposes only. No individual information is submitted.

PATIENT INFORMATION

Last Name: | **First Name:** | **M.I.:**

SSN: | **Birth Date:** | **Birth Sex:** ☐ Male ☐ Female ☐ Non-Binary ☐ Unknown

Mailing Address: | **City:** | **State:** | **ZIP:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **E-Mail:**

Contact for Reminder Calls and Other Electronically Generated Messages: (Choose One) ☐ Text ☐ Voice
Select Preferred Number: ☐ Home ☐ Cell ☐ Work

Marital Status: (Choose One)
☐ Single ☐ Separated
☐ Married ☐ Widow(er)
☐ Divorced

Race: (Choose One)
☐ Alaska Native ☐ Chinese ☐ Korean ☐ Other Asian
☐ American Indian ☐ Filipino ☐ Native Hawaiian ☐ Unknown
☐ Black/African American ☐ Japanese ☐ Patient Refused ☐ White

Ethnicity: (Choose One)
☐ Another Hispanic, Latino(a), or Spanish Origin ☐ Mexican, Mexican American, or Chicano(a) ☐ Patient Refused ☐ Unknown
☐ Cuban ☐ Non-Hispanic/Latino(a) ☐ Puerto Rico

Veteran Status: ☐ Veteran ☐ Non-Veteran | **Preferred Language:**

Farmworkers:
Has anyone in your household worked in agriculture (fields, orchards, etc.) in the past 2 years? ☐ Yes ☐ No
If yes, did that person work for less than 12 months out of the year? ☐ Yes ☐ No
If yes, did that person move from place to place for work? ☐ Yes ☐ No
Is anyone in your household a retired farmworker? ☐ Yes ☐ No

Living Status:
☐ Own ☐ Doubling Up
☐ Rent ☐ Street
☐ Public Housing ☐ Unknown
☐ Homeless Shelter ☐ Other:
☐ Transitional

IN CASE OF EMERGENCY

Name of Local Friend or Relative: (not living at same address)

Relationship to Patient: | **Phone Number:** | **Alternate Phone Number:**

RESPONSIBLE PARTY

Person Responsible: | **Birth Date** | **Mailing Address:** (if different) | **Home Phone:**

Occupation: | **Employer:** | **Employer Mailing Address:** | **Employer Phone Number:**

Family Size: (including self) | **Annual Household Income:**

Is this person a patient of Full Circle Health? ☐ Yes ☐ No | Is this patient covered by Insurance? ☐ Yes ☐ No

INSURANCE INFORMATION (Please give your insurance card to the Receptionist)

Name of Primary Insurance: ☐ IPN ☐ Tricare ☐ Blue Cross ☐ Blue Shield ☐ Medicare ☐ Medicaid ☐ Other:

Primary Medical Insurance	Secondary Medical Insurance
Subscriber's Name:	**Subscriber's Name:**
Subscriber's SSN:	**Subscriber's SSN:**
Subscriber's DOB:	**Subscriber's DOB:**
Patient's Relationship to Subscriber:	**Patient's Relationship to Subscriber:**
☐ Self ☐ Spouse ☐ Child ☐ Friend	☐ Self ☐ Spouse ☐ Child ☐ Friend
☐ Partner ☐ Dependent ☐ Parent ☐ Other	☐ Partner ☐ Dependent ☐ Parent ☐ Other

NOTE: MEDICARE SECONDARY RECIPIENTS NEED TO COMPLETE THE NEXT SECTION

☐ Medicare Secondary, Working Aged Beneficiary or Spouse with Employer Group Health Plan
☐ Medicare Secondary, Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
☐ Medicare Secondary, Other Liability Insurance is Primary
☐ Medicare Secondary, No-fault Insurance including Auto is Primary
☐ Medicare Secondary, Worker's Compensation
☐ Medicare Secondary, Veteran's Administration
☐ Medicare Secondary, End-Stage Renal Disease Beneficiary in the 12-month coordination period with an employer's group health plan
☐ Medicare Secondary, Public Health Service (PHS) or Other Federal Agency
☐ Medicare Secondary, Black Lung

FOR FULL CIRCLE HEALTH STAFF USE ONLY

If the patient or guardian refuses to sign/complete this form, please complete this section. Date offered to patient: / / FULL CIRCLE HEALTH Staff Initials:

CONSENT FOR OUTPATIENT TREATMENT

This form includes important information about how care is provided to patients at Full Circle Health ("Health Center"). Patients and parents, guardians, and other patient representatives should read this information carefully or ask for assistance to have the form read to you. By signing this form, you agree to receive care at the Health Center according to the following terms and conditions:

1. **Consent.** I request and authorize the Health Center and its physicians, residents, assistants and designees to provide the medical care and treatment necessary or advisable to me, or the patient identified below. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care.

2. **Emergencies.** I authorize the Health Center to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my, or the patient's, life or health.

3. **Risks and Benefits.** I am aware that the practice of medicine is not an exact science and I understand that the Health Center is not making any guarantees or promises about the results of the care received.

4. **Health Changes.** I understand that it is my responsibility to tell the Health Center if there are any significant change in my, or the patient's, physical or emotional condition.

5. **Testing.** I understand that samples of body fluids and/or tissues may be withdrawn during tests and procedures. I authorize the Health Center and its affiliates to perform other tests on these body fluids and/or tissues in order to further treatment.

6. **Medication Verification.** I authorize the Health Center to contact healthcare providers from whom I, or the patient, have received treatment to obtain medical information and/or records, including but not limited to, commercial pharmacies (i.e. Walgreens, CVS, Costco, etc.), and alcohol and other drug treatment records for verification of my medications and treatment.

7. **Transmittable Diseases.** I have been informed and understand that HIV (human immunodeficiency virus)/AIDS, HCV (hepatitis C virus) and HbsAg (hepatitis Bvirus) tests may be performed on me, or the patient, without my consent if a health professional, facility employee or First Responder sustains an exposure to my, or the patient's, blood or other body fluid.

8. **Personal Valuables.** I understand that I am responsible for any and all personal valuables that I bring with me, or the patient, to the Health Center. I hereby release the Health Center and its agents from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my, or the patient's, care and treatment.

9. **Residency Program.** Health Center patients are cared for by a medical team that includes a physician, a resident and a mid-level provider (PA, NP, and CNM). The physician and resident will be your primary providers. A resident "is a doctor who has received a medical degree (MD, DO) from an accredited medical school and who practices medicine under the supervision of a fully licensed

physician, usually in a hospital or clinic". I consent to having a resident and student involved in my, or the patient's, care.

10. **Acknowledgement of Privacy Practices.** The Health Center's Notice of Privacy Practices provides information about how protected health information about patients may be used or disclosed for purposes of treatment, payment or the Health Center's operations. Information about communicable diseases and infections, including venereal disease, tuberculosis, hepatitis B, HIV (AIDS virus) and AIDS related complex, alcohol and drug abuse treatment information, mental health treatment records, and reports of abuse, abandonment or neglect may be used and disclosed under certain circumstances. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Privacy Notice may change and that I may request a current copy from the Health Center at any time.

11. **Attendance Policy.** A copy of the Health Center's Attendance Policy has been made available to me. I understand it is my responsibility to know my, or the patient's, appointment dates and times and I understand that services may be discontinued in the event I, or the patient, do not attend scheduled appointments.

12. **Ending Treatment.** I understand that I have the right to terminate treatment at the Health Center at any time I choose to do.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS, AND HAVE THESE QUESTIONS ANSWERED.

_____ _____

Electronic Signature of Patient/Legal Guardian Date

INFORMED CONSENT FOR TELEHEALTH VISIT

I hereby consent to receiving treatment through telehealth from my Full Circle Health provider or a qualified member of his or her care team. If patient is a minor, I consent to have the minor (identified below) receive treatment through telehealth. I understand that "telehealth" is the mode of delivering health care services through information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. I understand that telehealth also involves the communication of my medical information, both orally and visually, to health care providers located at Full Circle Health or elsewhere.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I understand that receiving treatment through telehealth does not mean I cannot receive in-person health care services, either today or in the future. I understand that there are limitations to the types of treatment that can be appropriately provided via telehealth, and that my provider determines whether or not it is appropriate for me to receive treatment via telehealth.

(2) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I also understand that there are risks involved in receiving treatment via telehealth, such as interruption of the audio-video connection between me and my provider, or delays in receiving medical treatment because of technological failures.

(3) I understand that in some cases a patient may require an in-person visit following a telehealth visit to adequately assess or treat some health concerns, for procedures, immunizations, or other issues and I also understand that there will be an additional charge if an in-person visit is required.

(4) I understand that the patient must be located within the State of Idaho to participate in a telehealth visit.

I understand that I can discuss any questions that I have with my provider at the beginning of my telehealth visit, that my provider will answer any such questions, and that I may decline to continue the telehealth visit at any time.

By beginning my telehealth visit, I confirm that I have read and understand the information in this Informed Consent and give my informed consent to receive treatment via telehealth.

_____ _____

Electronic Signature of Patient Date

_____

Print Patient Name

_____ _____

Electronic Signature of Legal Guardian if Patient is a Minor Date

_____ _____

Print Guardian Name Relationship to Patient

AUTHORIZATION TO BILL INSURANCE, FINANCIAL RESPONSIBILITY, CREDIT POLICY

Authorization to Bill Insurance and Assignment of Benefits. The patient information is true to the best of my knowledge. I authorize Full Circle Health to directly bill my insurance company and I further authorize any third-party payer through which I have benefits to make payment directly to Full Circle Health. I understand that I am financially responsible for any balance. I also authorize Full Circle Health or insurance company to use and disclose any healthcare information for the purpose of obtaining payment for services and determining insurance benefits. Services provided by outside companies, (i.e., lab, pathology, radiology) are billed separately by those companies.

Financial Responsibility. I understand that I am financially responsible for the payment of medical charges incurred on my behalf at Full Circle Health, including charges that are not paid in full by my insurance, government program benefits, or other third-party payers. I also agree to pay or reimburse Full Circle Health for all costs it may incur in collecting such amounts, including, but not limited to, attorneys' fees and collection agency fees. Services provided by outside companies, (i.e., lab, pathology, radiology, durable supplies) are billed separately by those companies.

Credit Policy.

PHILOSOPHY: It is the desire of Full Circle Health to provide quality medical and behavioral health services without barriers to access. This policy guides us in providing access to care while also ensuring we collect amounts owed to us for the provision of services. For those patients with insurance coverage, we will properly bill insurance on a timely basis. If you do not have insurance coverage, we are sensitive to your financial constraints and do not want to impede access to care that is vital to your health. Full Circle Health will work with its patients on payment plans to absolve account balances but requires that the patient stay engaged in this process and follows the terms that have been agreed to.

PROCEDURE:

1. We will request payment at the time of service. If you are unable to pay the adjusted amount due at the time of appointment, we will ask that you pay what you can, and Full Circle Health will bill you the balance.
2. If you receive an account statement from us and cannot pay the entire balance, we request that you contact us within 30 days about a satisfactory payment plan to resolve the amounts due.
3. If you have not made any payments on your account and have not agreed to a payment plan to resolve the balance within 30 days, you will receive a notice that your account may be referred to an outside collection agency.
4. If you have not attempted to resolve your account with payment nor communicate with us regarding a payment plan, a final notification will be sent to your last known address informing you that your account is being referred to an outside collection agency. At the time your account is listed with the collection agency, your credit record may be adversely affected.

It is the experience of Full Circle Health that the vast majority of our patients understand and cooperates with our long-standing credit policy. Full Circle Health is disclosing our policy to you now, so that we may avoid any misunderstanding in the future. By signing you acknowledge that you have read, understand and agree to comply with this credit policy.

_____ _____

Electronic Signature of Patient/Legal Guardian Date

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare/Medigap benefits be made either to me or on my behalf to Full Circle Health for any services furnished me by Full Circle Health. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Electronic Signature of Patient/Legal Guardian Date

Full Circle Health

AUTHORIZATION TO VERBALLY USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO THIRD PARTY

By signing this authorization, I authorize Full Circle Health to verbally disclose certain protected health information (PHI) about me to the person named below for the purpose of coordinating my care with scheduling, nursing and provider staff. Specifically, the following information may be verbally discussed with the authorized individual: (Select all that apply.)

[ ] Manage Appointments
[ ] Substance Use Information
[ ] Payments, Billing Information
[ ] X-ray Reports and other images
[ ] Lab results
[ ] AIDS/HIV information
[ ] Give Medical Information
[ ] Mental Health Information
[ ] Receive Medical Information
[ ] All of the Above
[ ] Other _____

_____
Name of person who may receive your PHI

_____
Relationship to Patient

_____
Phone Number

This authorization will expire on ☐ Until Death ☐ Until Revoked ☐ Date ___/___/____.
(Expiration Date or Defined Event. If no date indicated, this authorization will expire one year from the date it was signed.)

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the person who receives it and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Full Circle Health acted in reliance upon this authorization. My written revocation must be submitted to Full Circle Health Privacy Officer at 777 N. Raymond St., Boise, ID 83704. I understand that Full Circle Health may not condition patient's healthcare on this authorization unless the purpose for provider's evaluation and treatment is to disclose information consistent with this authorization.

_____
Print name of patient whose PHI may be released

_____
Date of Birth or Social Security #

Signed by: _____
Signature of Patient or Legal Guardian

☐ Self ☐ Guardian

_____
Date

FOR INTERNAL USE ONLY

Date Request Received_____

NEW PATIENT HISTORY FORM

Legal Name: _____

Preferred name: _____

DOB: _____

Thank you for taking the time to complete this form.
If you have entered any of this information into your MyChart, you do not need to relist.

Please list all current health issues:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Please list all current medications with doses and frequencies (include over the counter medications and natural remedies):

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Preferred Pharmacy:_____

Please list all Allergies:

- _____
- _____
- _____

Please list all surgeries and years in which they occurred:

- _____
- _____
- _____
- _____
- _____
- _____

Family History (check all that apply):

Relationship	Alcohol/drug use	Arthritis	Asthma	Cancer (Type?)	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Liver Disease	Mental Illness	Stroke	Vision Issues	Other_____
Mother															
Father															
Sister															
Brother															
Daughter															
Son															
Maternal Aunt															
Paternal Aunt															
Maternal Uncle															
Paternal Uncle															
Maternal Grandmother															
Maternal Grandfather															
Paternal Grandmother															
Paternal Grandfather															
Other															

☐ I am adopted ☐ I don't know my family history

Habits:

Do you smoke? ☐Never ☐Previously ☐Current **Use smokeless tobacco or vape?** ☐Yes ☐No

Quit Date: _____ Pack/day: _____ Years smoked: _____

Do you drink alcohol? ☐Never ☐Previously ☐Current

How often do you drink? ☐ Less than once/mo ☐2-4x/mo ☐2-3x/week ☐Most days

How many drinks do you have on a day you are drinking: _____

Do you use drugs? ☐Never ☐Previously ☐Current **Have you ever injected drugs?** ☐ Yes ☐ No

Type of drug(s) used:

☐ Benzodiazepines ☐ Ecstasy ☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Methamphetamine ☐ Opioids

Are you currently sexually active? ☐ Yes ☐ Not right now ☐ Never

Are you and your partner(s) using a birth control method? ☐Yes ☐No

If yes, select/circle all that apply:

❑ Condoms ❑ Vaginal ring ❑ Pill ❑ Patch ❑ IUD
❑ Nexplanon ❑ Depo injection ❑ Spermicide
❑ Tubal ligation ❑ Vasectomy ❑ Withdrawal

What types of partners do you have:

☐ Male ☐ Female ☐ Both

Pregnancy History: ☐This does not apply to me

How many pregnancies have you had? _____

How many deliveries? _____

Sexual Orientation Gender Identity:

Gender Identity:
☐ Female
☐ Male
☐ Transgender Female / Male-to-Female
☐ Transgender Male / Female-to-Male
☐ Other
☐ Choose Not to Disclose
☐ Non-Binary / Gender Queer
☐ Questioning

Preferred Pronouns:
☐ She/Her/Hers
☐ He/Him/His
☐ They/Them/Theirs
☐ Ze/Hir/Hirs
☐ Ey/Em/Eirs
☐ Xe/Sem/Xyrs
☐ Ve/Vir/Vis
☐ Other
☐ Patient's Name
☐ Unknown

NOTICE OF PRIVACY PRACTICES

Effective Date: 06/01/2013

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.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or disclose your health information for certain purposes without your written authorization, including the following:

   ☐ **Treatment.** We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

   ☐ **Payment.** We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

   ☐ **Healthcare Operations.** We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect, or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.
- For certain specialized government functions such as the military or correctional institutions.
- For research purposes if certain conditions are satisfied.
- In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.
- To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

Organized Health Care Arrangement. Full Circle Health (FCH) is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org as a business association of FCH, OCHIN supplies information technology and related services to FCH and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of participating organizations to establish best practice standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by FC H with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive. The personal information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information to the extent disclosed, will be disclosed consistent with the Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent, however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

2. **Disclosures We May Make Unless You Object.** *Unless you instruct us otherwise*, we may disclose your information as described below.
   - To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.
   - To maintain our facility directory. If a person asks for you by name, we will only disclose your name, general condition, and location in our facility. We may also disclose your religious affiliation to clergy.
   - To contact you to raise funds for our organization. You may opt out of receiving such communications at any time by notifying the Privacy Officer identified below.

3. **Uses and Disclosures with Your Written Authorization**. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already taken action in reliance on the authorization. Other uses or disclosures not described in this notice require a written authorization.

4. **Your Rights Concerning Your Protected Health Information.** You have the following rights concerning your health information.
   - You have the right to receive notification if the event of a breach of your unsecured protected health information.
   To exercise any of the rights listed below, you must submit a written request to the Privacy Officer identified below.
   - You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer.
   - We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests.
   - You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others.
   - You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record or if we determine that the record is accurate and complete.
   - You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period.
   - You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. **Changes to This Notice.** We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. **Complaints.** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

	HIPAA Privacy Officer
Phone:	208-514-2522
Address:	777 N Raymond St. Boise, ID 83704
E-mail:	CQO@fullcircleidaho.org

Full Circle Health

Thank you for allowing **Full Circle Health** to be your primary care home for your medical needs. We are committed to providing you with high quality healthcare centered on you. We promise to respect you as an individual, and as a whole person.

As a member of Full Circle Health, you have access to:

- Same Day Appointments
- 24-hour Nurse Care Line
- Coordination of your care at home and in the hospital
- Pharmacy Services
- Referrals to the best available specialists
- Telehealth Appointments (Medical & Behavioral Health)
- Online access using MyChart at **www.MyFullCircle.org** to:
    - Your Medical Records
    - Your Lab Results
    - Communicate with your Doctor via e-mail
    - Your Immunization Records

Our goal as your Patient Centered Medical Home is for you to receive the best possible health care, and we look forward to working alongside you to accomplish this.

For Appointments in Ada County: Call (208) 514-2500
For Appointments in Canyon County: Call (208) 514-2529
For after-hours care, call any of our clinic locations and we would be happy to help assist you and your medical needs after our clinics are closed.

Full Circle Health Pharmacies

Emerald Pharmacy
6565 W Emerald St.
Boise, ID 83704
PHONE: 208-514-2512

Meridian Pharmacy
2275 S Eagle Rd., #120
Meridian, ID 83642
PHONE: 208-954-8722

Nampa Pharmacy
215 E Hawaii Ave., #140
Nampa, ID 83686
PHONE: 208-954-8731

Boise Pediatrics
8610 W Overland Rd.
Boise, ID 83709
PHONE: 208-954-8711

Caldwell Clinic
315 E Elm St., #201
Caldwell, ID 83605
PHONE: 208-514-2528

Emerald Clinic & Wellness Center
6565 W Emerald St.
Boise, ID 83704
PHONE: 208-514-2510

Idaho Street Clinic
325 W Idaho St
Boise, ID 83712
PHONE: 208-514-2525

Kuna Clinic
708 E Wythe Ck Ct., #103
Kuna, ID 83634
PHONE: 208-922-5130

Meridian Clinic
2275 S Eagle Rd., #120
Meridian, ID 83642
PHONE: 208-514-2520

Nampa North Clinic
9850 W St Luke's Dr., #329
Nampa, ID 83687
PHONE: 208-514-2509

Nampa South Clinic
215 E Hawaii Ave., #140
Nampa, ID 83686
PHONE: 208-514-2529

Nampa Pediatrics
215 E Hawaii Ave., #140
Nampa, ID 83686
PHONE: 208-514-2502

Raymond Clinic
777 N Raymond
Boise, ID 83704
PHONE: 208-514-2500