Full Circle Health

**Full Circle Health is a Federally Qualified Health Center that gets support from the federal government. We ask all patients to share some basic information, like age, gender, race, income, and how many people are in their family. This information is only used for general statistics, and no personal details are shared.**

## PATIENT INFORMATION

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

| **Birth Date:** | **SSN:** | **Birth Sex:** ☐ Male ☐ Female | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widow(er) |
|---|---|---|---|
| | | | |

| **Mailing Address:** *(Please include apartment number if applicable)* | **City** | **State:** | **ZIP:** |
|---|---|---|---|
| | | | |

| **Cell Phone:** | **Home:** | **Other:** | **Email:** |
|---|---|---|---|
| | | | |

| **Veteran Status:** ☐ Veteran ☐ Non-Veteran | **Employment Status:** ☐Full-time ☐Part-Time ☐Self-Employed ☐Retired ☐Student |
|---|---|
| **Preferred Language:** | **Automated Text Reminders:** ☐ Yes ☐ No |

## PARENT OR LEGAL GUARDIAN's IF PATIENT IS UNDER THE AGE 18

| **Name:** | **Birth Date:** | **Phone:** | **Relationship:** |
|---|---|---|---|
| | | | |
| **Name:** | **Birthdate:** | **Phone:** | **Relationship:** |
| | | | |

**Address:** *(If Different from Patient)*

## EMERGENCY CONTACT

| **Name:** | **Phone:** | **Relationship:** |
|---|---|---|
| | | |

**Race:** (Choose All that Apply)
- ☐ Alaska Native
- ☐ American Indian
- ☐ Asian Indian
- ☐ Black/African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Unknown
- ☐ Patient Refused

**Ethnicity:**
- ☐ Another Hispanic, Latino(a) or Spanish Origin
- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano(a)
- ☐ Multiple Hispanic, Latino(a), or Spanish Origins
- ☐ Non-Hispanic/Latino(a)
- ☐ Puerto Rican
- ☐ Unknown
- ☐ Patient Refused

**Living Status:**
- ☐ Own
- ☐ Rent
- ☐ Public Housing
- ☐ Homeless Shelter
- ☐ Transitional
- ☐ Doubling up
- ☐ Street
- ☐ Unknown
- ☐ Other

**Farm Workers:**
- ☐ Migrant
- ☐ Seasonal
- ☐ Neither

**Family Size:**

**ANNUAL HOUSEHOLD INCOME:**
- ☐ $0-15,960
- ☐ $15,961 - $23,940
- ☐ $23,941 - $27,930
- ☐ $27,931 - $31,920
- ☐ $31,921 - $39,900
- ☐ $39,901 - $43,890
- ☐ $43,891 - $50,000
- ☐ $50,001 - $60,000
- ☐ $60,301 - $75,000
- ☐ $75,001 - $80,000
- ☐ $80,001 - $85,000
- ☐ $85,001 - $90,000
- ☐ $90,001 - $95,000
- ☐ $95,001 - $100,000
- ☐ $100,000 - $105,000
- ☐ $105,001 -$110,000

## MEDICAL INSURANCE INFORMATION

| **Policy Holder Name:** | **Birth Date:** | **Primary Insurance:** | **Secondary Insurance:** |
|---|---|---|---|
| | | | |

**Relation to Patient:** ☐ Self ☐Spouse ☐ Child ☐Partner ☐ Parent ☐ Dependent ☐ Friend ☐ Other

# 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 understand that if a healthcare professional, facility employee, or first responder is exposed to my blood or other body fluids while providing care, certain blood tests may be performed. These tests may include HIV (human immunodeficiency virus/AIDS), Hepatitis C (HCV), and Hepatitis B (HBsAg).

8. I understand that, in this specific situation, these tests may be required by law and may be performed without my prior consent to help protect the health and safety of the exposed individual.

9. **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.

10. **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.

13. **Use of Artificial Intelligence (AI) in Medical Documentation.** I understand that Full Circle Health may use secure, HIPAA-compliant computer tools, called artificial intelligence (AI), to help providers create and maintain my medical notes. These tools support accuracy and efficiency but do not replace the professional judgment of my healthcare provider. I may ask questions at any time and can request that AI not be used for my visit notes.

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

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: _____ ☐ Self ☐ Guardian
Signature of Patient or Legal Guardian

_____
Date

**FOR INTERNAL USE ONLY**

Date Request Received_____

Full Circle Health

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient First and Last Name: _____

Date of Birth: _____ Address: _____

Telephone: _____ Email Address: _____

Other names under which the Patient has been treated: _____

**I Authorize:**

Name: Full Circle Health

Address: 777 N Raymond St. Boise, ID 83704

Telephone: (208) 514-2500 Fax: (208) 375-2217

[ ] To **release** my confidential health information to: [ ] To **request** my confidential health information from:

Name: _____

Address: _____

Telephone: _____ Fax: _____

[ ] Patient pick up paper copies [ ] Patient Portal/ MyChart [ ] Records on a Flash Drive [ ] Copies by Fax

For the following purpose: (check one or more)

[ ] to provide treatment [ ] coordination of care [ ] at the request of the patient

[ ] marketing/fundraising [ ] transferring care [ ] Other _____

***I authorize PROVIDER and its employees, agents, or associated healthcare practioners to use or disclose the Patient's protected health information as described below.***

[ ] Office visits [ ] Accounting of visits [ ] X-Ray reports and other images

[ ] Consultation reports [ } Pathology tests [ ] Complete patient chart

[ ] Lab tests [ ] Charges, payments, billing information [ ] Other _____

[ ] Mental Health/Counseling Notes

Healthcare provided between (date): _____ and (date): _____

This authorization will expire on the following date or event: _____. If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

- I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

  ***Full Circle Health: 777 N Raymond St. Boise, ID 83704***
- I understand that PROVIDER may not condition the Patient's healthcare on this authorization unless the purpose for PROVIDER's evaluation is to obtain and disclose information to entities consistent with this authorization, the Patient is involved in research-related treatment and use, or disclosure is for such research.
- I understand that information disclosed by PROVIDER pursuant to the authorization may be re-disclosed by the entity that receives this information and may no longer be protected by privacy regulations.
- I understand I may be charged if more than 15 pages are copied, and that payment is due prior to release of records.

_____ _____

Patient/Guardian Signature Date

_____

Authority or relationship to the Patient

| For Office Staff Only |
|---|
| Received: _____ |
| Processed: _____ |
| Amount: $ _____ |

# 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:**

| Sexual Orientation: |
|---|
| ☐ Straight or Heterosexual |
| ☐ Bisexual |
| ☐ Something Else |
| ☐ Don't Know |
| ☐ Choose Not to Disclose |
| ☐ Gay |
| ☐ Lesbian |
| ☐ Pansexual |
| ☐ Queer |
| ☐ Omnisexual |
| ☐ Asexual |

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

| 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 |
| ☐ Decline to Answer |
| ☐ Unknown |

# NOTICE OF PRIVACY PRACTICES

**Effective Date: 06/01/2013 Revised Date: 02/01/2026**

**THIS NOTICE EXPLAINS HOW YOUR MEDICAL INFORMATION MAY BE USED AND SHARED. IT ALSO EXPLAINS YOUR RIGHTS TO SEE AND GET A COPY OF YOUR INFORMATION. PLEASE READ IT CAREFULLY.**

We are required by law to protect the privacy of your health information. We must tell you about our privacy practices, follow the terms of this Notice, and notify you if there is a breach of unsecured health information.

This Notice explains how we may use and share your health information and describes your rights. The full legal rules are found in federal law at 45 CFR Part 164. We must follow the Notice that is currently in effect.

This Notice also explains your rights under updated federal privacy rules. These include rules about getting copies of your records, using electronic health information, protecting reproductive health information, and the use of artificial intelligence (AI), when applicable.

**Use of Technology and Artificial Intelligence (AI)**

We may use technology, including artificial intelligence (AI), to help with things like scheduling, medical notes, quality improvement, and office tasks. These tools are used in ways that protect your privacy and follow state and federal laws.

Full Circle Health may use an AI scribe to help write notes during your visit. You may ask questions about this tool. When available, you can tell your care team if you do not want to use the AI scribe. This will not affect your care or benefits.

**Legal Duties:**

We are required by law to:

- Protect the privacy of your protected health information (PHI);
- Give you this Notice explaining our privacy practices;
- Follow the terms of this Notice; and
- Notify you if there is a breach of unsecured PHI.

These duties are required under HIPAA, the federal law that protects patient health information.

1. **Uses And Disclosures We May Make Without Written Authorization.** We may use or share your health information without your written permission for the reasons listed below:

   - ☐ **Treatment.** We may use or share your information to provide you with medical care. For example, we may share information with another health care provider, remind you about appointments, or tell you about treatment options or services we offer.

   - ☐ **Payment.** We may use or share your information to receive payment for services we provide. For example, we may share information with your health insurance company to get approval or payment for care.

   - ☐ **Healthcare Operations.** We may use or share your information to run our organization and improve care. For example, we may review staff performance, train employees, or make decisions to improve services.

**Other Uses or Disclosures.** We may also use or share your information as allowed by law, including:

- To prevent a serious threat to your health or safety, or the safety of others
- When required by state or federal law, such as reporting abuse or neglect
- For workers' compensation claims
- For public health activities, such as reporting diseases
- For health oversight activities, such as audits or inspections

- In response to a court order, subpoena, or warrant
- For certain government activities, such as military or correctional purposes
- For approved research purposes
- For law enforcement purposes, such as locating a missing person or reporting a crime
- To coroners, funeral directors, or organ donation organizations as needed

1.a. **Electronic Communications & Telehealth.** We may contact you electronically, such as through patient portals, text messages, email, or telehealth platforms, about your care or appointments. Electronic communication may involve some risk. You may ask us to limit how we contact you or request another method at any time.

1.b. **Reproductive Health Information Protections.** We will not use or share your reproductive health information for law enforcement or legal actions related to lawful reproductive health care. We will only share this information if required by law or if you provide valid written permission, when applicable.

**Organized Health Care Arrangement.** Full Circle Health (FCH) is part of an organized health care arrangement with OCHIN and its participants. A list of OCHIN participants is available at www.ochin.org.

OCHIN provides information technology and support services, including electronic health record systems. OCHIN also helps with quality improvement and coordination of patient referrals.

Your health information may be shared with other OCHIN participants or health information exchanges when needed for treatment or health care operations. This may include information about past, current, or future care. Any sharing of information follows HIPAA and other applicable laws.

2. **Disclosures We May Make Unless You Object.** *Unless you tell us not to,* we may share your information as described below.

   - With a family member, friend, or other person involved in your care or payment for care. We will only share information related to their involvement.
   - For our facility directory. If someone asks for you by name, we may share your name, general condition, and location. We may also share your religious affiliation with clergy.

   2.a. **Fundraising Communications.** We may contact you to raise funds for our organization. You may opt out of fundraising communications at any time by contacting our HIPAA Privacy Officer or providing written notice. Opting out will not affect your care or payment.

3. **Uses and Disclosures with Your Written Authorization.** We will only use or share your information for reasons not listed in this Notice if you give us written permission. This includes most uses of psychotherapy notes, marketing purposes, or selling your information.

   You may cancel your permission at any time by writing to the Privacy Contact listed below. This will not affect actions already taken based on your permission.

4. **Your Rights Concerning Your Protected Health Information.**
   - You have the right to be notified if there is a breach of your unsecured health information.

   *To use the rights below, you must submit a written request to the HIPAA Privacy Officer.*

   - You may ask us to limit how we use or share your information. We do not have to agree unless you pay in full for a service and ask us not to share that information with your health insurer.
   - You may ask us to contact you in a different way or at a different location. We will honor reasonable requests.
   - You may see or get a copy of your medical or billing records, including an electronic copy. We may deny access in limited cases, such as if it could cause harm.

- You may ask us to correct your health information. We may deny the request if we did not create the record or if it is accurate and complete.
- You may request a list of certain times we have shared your information. One list per 12 months is free. We may charge a fee for additional requests.
- You may request us to send an electronic copy of your health information to a person or organization you choose, if possible.

5. **Changes to This Notice.** We may change this Notice at any time. Changes will apply to all health information we have. If we make major changes, we will post the updated Notice in our reception area and on our website. You may request a copy at any time.

6. **Complaints.** You may file a complaint if you believe your privacy rights have been violated. You may complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. **Contact Information.** If you have questions, want to exercise your rights, or wish to file a complaint, please contact:

| | |
|---|---|
| Privacy Officer: | 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

# Full Circle Health No-Show Policy

At Full Circle Health, we strive to provide quality care for all our patients. When a scheduled appointment is missed without prior notice, it impacts our ability to serve others who may need medical attention during that time.

## What is a No-Show?

A "no-show" occurs when you do not attend your scheduled appointment and do not contact us at least 24 hours in advance to cancel or reschedule.

## Why Does This Matter?

When you miss an appointment without notifying us, it prevents us from offering that time to another patient. Your consideration helps us provide timely care to everyone.

## Our No-Show Policy:

- **Established Patients (anyone we have seen once or more)**: if you miss three (3) appointments within twelve (12) consecutive months without 24-hours' notice, we can no longer provide you with care at any of our Full Circle Health facilities.

- **New Patients (patients we have never seen):** if you cancel and/or miss two (2) appointments within the first twelve (12) consecutive months of being a patient without 24-hours' notice, we can no longer provide you with care at any of our Full Circle Health facilities.

## How to Avoid Being a No-Show:

- Call us at least 24 hours in advance of your appointment time if you need to cancel or reschedule.
- Our team is happy to assist you in finding a time that works better for your schedule.

We value your partnership in helping us provide excellent care for all our patients. Thank you for your understanding and cooperation.

If you have any questions about this policy, please contact our office.