Pain Care Clinic of Idaho

Feel like yourself again

Welcome to our practice!
Thank you for choosing Pain Care Clinic of Idaho.

We are located on an unmarked private road off of **old State Street in Eagle, Idaho**. Turn north, just before the northwest corner of Idaho Central Credit Union building. We are directly south of the Eagle Post Office. We are tucked in next to the Woodington Veterinary Clinic.

Before you come in, we thought you might appreciate knowing a little bit about us, and getting an idea of what you can expect during your visit.

Our philosophy is different than most pain clinics. We believe in a non-narcotic approach to your pain, including but not limited to: **Medical Acupuncture**, and three new advanced cutting-edge techniques, using **InterX Therapy, Alpha Stim-M®** and **Scrambler Therapy® Technology.** Multiple techniques may be used in your treatment protocol.

During your initial consultation, we will ask you questions regarding your medical history, which is vital in having your condition assessed by Dr. Boese and will be used in developing your treatment plan.

After your consultation he will discuss all options with you, and diagnostic testing will be administered at that time. Once treatment is determined, we can then discuss financial arrangements with you. If you have insurance, we ask that you pay your co-pay, or your estimated portion on the day treatment is. If you do not have insurance, or your insurance does not cover specific treatments, we ask that you pay for services on that day in full.

(We accept Visa, Master Card and Care Credit). If this poses a hardship, we will work with you to develop an alternative financial arrangement.

Please complete the attached new patient paperwork and bring it with you to your appointment. **We ask that you wear loose fitted clothing.** Some examples could be elastic waist shorts and a tank top. **Please do not wear lotions or oils, a high neck top, spandex, or a sports bra.** Please make sure you are well rested and do not eat a heavy meal prior to your appointment. If you are taking herbal supplements, pain medication, muscle relaxers, or medications such as Lyrica, Gabapentin (Neurontin) and the like, **please consider skipping or lowering your dosage prior to your appointment** as they interfere with the neuropathic signal. If you have any questions about our clinic or services, please call us at any time. Feel free to visit us on our website at www.painclinicidaho.com

We welcome you to our practice, and look forward to meeting you!

Pain Care Clinic of Idaho, P.C.

742 E. State Street, Suite 150
Eagle, ID 83616 208-939-3750

Last Name: _____ First Name: _____ Middle Initial: ____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth date: _____ Sex: M / F Marital Status: M / S Social Security #: _____

Telephone: (_____) _____ Cell: (____) _____ Email: _____

Emergency Contact: _____ Phone: (_____) _____

Occupation: _____ Employer: _____ Office #: _____

Primary Care Physician: _____ Address:_____Phone:_____

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Policy Number: _____ Group Number: _____

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's Date of Birth: _____ Patient Relationship to Subscriber: _____

Policy Number: _____ Group Number: _____

There will be a $25.00 fee charged for all returned checks and a $40 fee charged for missed appointments. Since we reserve 90 minutes for your first visit, please let us know as soon as possible if you are not able to keep your appointment. Thank you! We require a minimum of 24 hours notice for cancellations. _____ (please initial)

Our office will provide insurance billing services for you if you so desire as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. **It is your responsibility to pay any deductible amount, co-insurance, and/or any other balances not covered by your insurance.**

Your signature indicates that you agree to pay for any outstanding bills incurred in this office.
I authorize that payment be made directly Pain Care Clinic of Idaho, P.C.

I also authorize the release of any information concerning my health and healthcare services to my insurance companies, Medicare, or other pre-paid healthcare plans**. I understand that there is no guarantee that my insurance companies or pre-paid healthcare plan will cover or pay for all of my charges, and I understand that I am responsible for all remaining charges.**

We are available Monday through Friday from 9-5 excluding holidays. If you require after hours care, please contact your Primary Care Physician.

_____I have read the HIPAA Privacy Notice (if you would like a printed copy to take home, please ask).
Please initial

_____ _____
Patient Signature Date

How did you hear about our office (check all that apply)
Web_____Friend/Family_____Newspaper/Ad_____Magazine_____TV_____Chamber_____Other_____

Pain Care Clinic of Idaho
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HEALTH INFORMATION FORM

Patient Name: _____Date: _____

Whom may we thank for referring you? _____

Primary Physician_____Phone Number_____Date of last visit_____

If there any confidential matters that you would like to discuss with Dr. Boese personally regarding your health history, diseases, medications or addictions that may interfere with your treatment please indicate here. YES _____NO_____

Reason for Visit:

What is your primary complaint? _____

_____

Neuropathic Pain Evaluation

Please Circle the answer that best describes your pain:

Does your pain include burning:	Yes	No
Do you have a painful cold feeling?	Yes	No
Does your pain involve electric shock?	Yes	No
Do you have tingling?	Yes	No
Do you feel pins and needles?	Yes	No
Do you have numbness?	Yes	No
Do you have itching?	Yes	No
Is your skin sensitive or does it hurt to touch?	Yes	No

How Severe is your pain? 0= No pain, 10= Unbearable pain 0 1 2 3 4 5 6 7 8 9 10

What treatment have you had for these complaints? Where and When_____

_____

_____

Have you had X-rays, MRI's or other tests for this condition? Yes_____ No_____ Date:_____

Location:_____Type:_____**P**

Past History:

Please indicate in detail if you have had any of the following, including dates to the best of your recollection:

Surgeries: Yes_____ No_____ Describe_____

_____

_____

_____

_____

Hospitalizations: Yes_____ No_____ Describe_____

_____

Major Injuries or Trauma: Yes_____No_____Describe_____

_____

_____

Major Illnesses: Yes_____No_____Describe_____

_____

Cancer: Yes_____ No:_____ When:_____Type:_____ Treatment:_____

Oncologist name: _____ Phone Number: _____

Female Gynecological History:

Live Births: _____

Miscarriages: _____

Hysterectomy or Surgery:

_____

_____

Other:

_____

Family History:

Please indicate if anyone in your immediate family has a history of the following:

Arthritis: Yes_____ No_____Relationship_____Disease_____

Heart Disease/Stroke: Yes_____ No_____Relationship_____Disease_____

Cancer: Yes_____ No_____ Relationship_____Disease_____

Diabetes: Yes_____No_____ Relationship_____Disease_____

Genetic Disorders: Yes_____ No_____ Relationship_____Disease_____

Other: _____

General Health Questions:

Do you currently use tobacco of any kind? Yes_____ No_____ How often? _____

What form of tobacco? _____

Former smoker Yes _____ No _____ Duration of use:_____

Do you use alcohol? If so how often? _____

Allergies: (Food, Meds, Environmental) _____

_____

Current Medications and Dosages/Reason: _____

_____

Do you take any supplements: Please list: _____

_____

Blood Pressure_____Weight (lbs.) _____Height (inches)_____

Is there any other information you could share with the Doctor that would be helpful to your treatment?

_____

_____

Pain Care Clinic of Idaho
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Review of Systems

Patient Name: _____ **Date:** _____

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fractures
- ☐ Headaches
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Herniated Disk
- ☐ HIV
- ☐ Influenza
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lumbago
- ☐ Malaria
- ☐ Measles
- ☐ Mental Disorder
- ☐ Migraines
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Small Pox
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Infection
- ☐ Whooping Cough

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST * CIRCLE ANY CURRENT HEALTH PROBLEMS

MUSCUO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Trouble
- ☐ Weight Gain/Loss
- ☐ Abdominal pain
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stools
- ☐ Colitis

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

CARDIO / RESPIRATORY

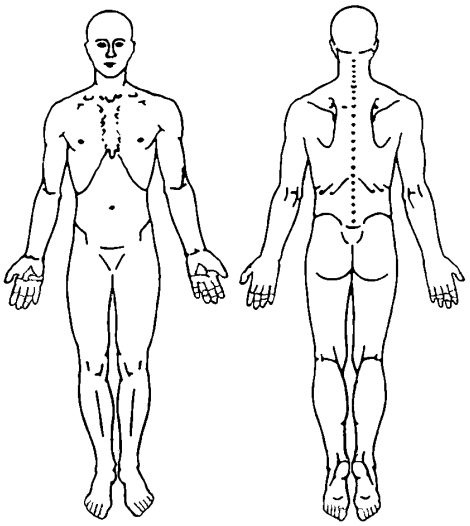
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes
- ☐ Currently Pregnant



Please outline on diagram the area of your discomfort.

Pain Care Clinic of Idaho

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Consent to Treat and Authorization to Release Information

I give my consent to an examination as needed to evaluate and or diagnose my medical condition.

I also consent to therapeutic procedures that are deemed necessary by Edmund C. Boese M.D. in the course of treatment. These therapeutic procedures may include any of the following: Scrambler Therapy® Technology, Alpha Stim-M®, Medical Acupuncture, Trigger Point Injections, InterX, IMS, Detoxification, Laser Therapy, Yoga/Exercise/Meditation, Herbal Supplementation and any other procedures as prescribed by Dr. Boese.

Dr. Boese and staff make every effort within their power to minimize risks involved in any procedure. In spite of that, there may be a very small risk of complications.

I have read the above information and my signature gives consent for evaluation, examination and treatment. I understand that I may question any procedure at any time. I also understand that I may decline if I am not completely comfortable with any procedure.

This procedure has been explained to me and I fully understand and I hold harmless Edmund C. Boese M.D. for this procedure.

☐ Pacemaker in place, risks explained. _____ Initial

☐ Spinal Stimulator in place, risks explained. _____ Initial

I hereby provide authorization for Edmund C. Boese, M.D. and staff to complete insurance claims on my behalf, and understand that records will be held in confidence and not released for any other purpose.

_____ **(initials)** I have read and understand the **HIPAA** privacy notice.

_____

Patient (Print Name)

_____ _____

Signature Date

_____ _____

Signature of Parent (if Minor) Date

Financial Responsibility

All patients are required to sign a financial responsibility and authorization for treatment form.

Your insurance may determine the care you have received is NOT a covered benefit. Please read your insurance handbook and be aware of what your insurance offers for benefits. When in doubt contact your insurance company directly for clarification. You will be responsible for care not covered by your insurance plan.

- Not a Covered Benefit - is not covered or only partially covered by your insurance plan, also excluded may be work injury or auto accidents.
- Not deemed medically necessary - not provided as the result of illness or injury.
- Before or after Eligibility - services provided during a period your policy is not in effect.

GENERAL

It is the policy of the Pain Care Clinic of Idaho that patients are prepared to pay their required co-payment and deductibles at the time service is rendered.

FINANCIAL ARRANGEMENTS, SELF-PAYMENT OR SELF-PAY

Pain Care Clinic of Idaho requires full payment at the time service is rendered. We have one set fee schedule. If patients do not have private insurance, Medicaid, Medicare, or a covered benefit plan, payment plans are available. All financial arrangements must be approved by the Office Manager.

- All cash patients and patients that present without valid insurance information are considered a Self-Pay Patient.
- All Self-Pay patients are required to pay at the time service is rendered.
- Please be prepared to make this payment with the front desk personnel after your visit.

HEALTH INSURANCE

Your insurance is a contract between you and the insurance company. For your convenience, we will be happy to submit your charges to your insurance company in y our behalf. Please be aware that not all services we provide are covered under any policy. While the filing of insurance claims is a courtesy that we extend to our patients, all charges including deductibles and co-pays are your responsibility.

MEDICARE/ MEDICAID

We accept patients with Medicare and/or Medicaid coverage. These programs provide limited coverage and do not pay for commonly used procedures in this clinic including Scrambler Therapy® and Medical Acupuncture.

Medicare patients are responsible for deductibles, co-pays and all non-covered services.
Medicaid patients are responsible for non-covered services.

There will be a $25.00 fee charged for all returned checks and a $40 fee charged for missed appointments. Since we reserve 90 minutes for your first visit, please let us know as soon as possible if you are not able to keep your appointment. We require a minimum of 24 hours' notice for cancellations. _____ (please initial) Thank you!

We accept Cash, Checks, Visa, Master Card and Care Credit

My signature indicates I have read and understand this financial policy.

Signature_____**Date**_____

Pain Care Clinic of Idaho, P.C.
HIPAA Privacy Authorization Form

1. I_____ authorize Pain Care Clinic of Idaho, P.C. to use and disclose the protected health information as described below.

2. This authorization for release of information covers all past, present, and future periods.

3. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by Pain Care Clinic of Idaho, P.C for my medical treatment, consultation with my Primary Care Provider, insurance billing, claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

6. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

7. I give my permission to Pain Care Clinic of Idaho P.C. to speak to my spouse/significant other/child

regarding my care_____ _____
Name Phone

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and

_____
Relationship to patient

_____
Date

Pain Care Clinic of Idaho, P.C.

742 E. State Street, Suite 150 Eagle, ID 83616 208-939-3750 info@pccofid.com

HIPPA Privacy Notice

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 respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining you; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- Disclosures of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- **Unless you object, we will also share relevant information about your health care with your family or friends who are helping you with your care**.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we

cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office address listed at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office at the address, fax or e-mail shown at the beginning of this notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office at the address, fax or e-mail shown at the beginning of this notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office at the address, fax or e-mail shown at the beginning of this notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office at the address, fax or e-mail shown at the beginning of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office at the address, fax or e-mail shown at the beginning of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address, fax or e-mail shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address, fax or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of this Notice of Privacy Practices for Pain Care Clinic of Idaho, P.C.

Patient name _____

Signature _____ **Date** _____

Pain Care Clinic of Idaho, P.C.
Edmund C. Boese, M.D.

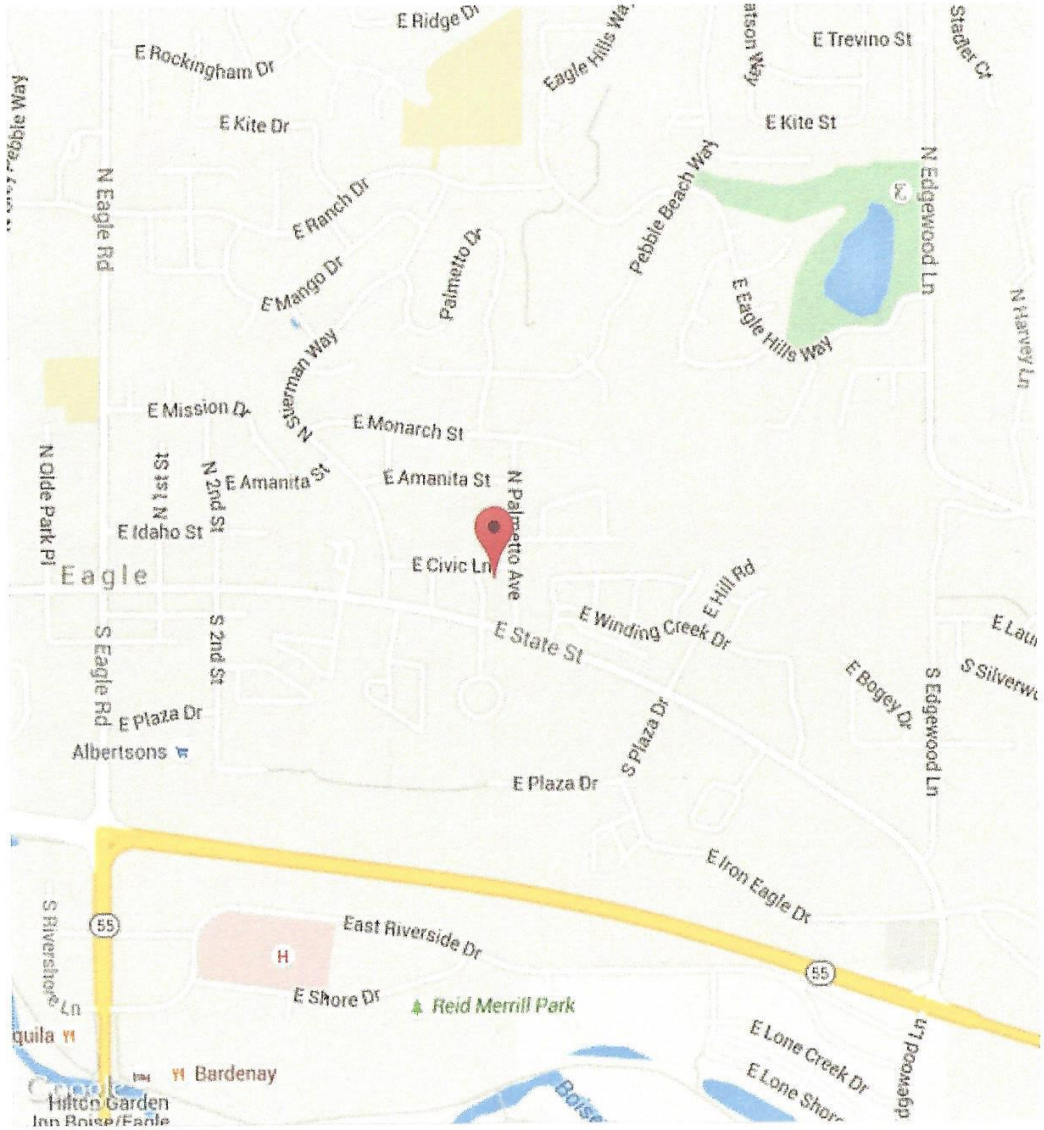
Find Us

Our Location

We are conveniently located at 742 E. State Street, Suite 150. Our clinic is located off old State Street in

Eagle, ID directly across from the Eagle Post Office. Turn north off old State Street onto an unmarked

street on the west end of Idaho Central Credit Union and then turn immediately right into our parking



Pain Care Clinic of Idaho, P.C.
Edmund C. Boese, M.D.
742 E. State Street Suite 150
Eagle, ID 83616
208-939-3750
Fax 208-939-3754

Release of Medical Information:

I, _____, _____, authorize the
(patient's name) (patient's DOB)

release of my medical records to Edmund C. Boese M.D. at Pain Care Clinic of Idaho, P.C.

Patient's Signature_____ Date _____

Requesting records from:

Name of Practice:_____

Name of Physician:_____

Fax number:_____

Address:_____

Please send records to:

Fax to: **208-939-3754**

Or mail to**:** **Pain Care Clinic of Idaho, P.C.**
Edmund C. Boese, M.D.
742 E. State Street, Suite 150
Eagle, ID 83616