Name:_____
Last First MI Prefers to be called/Nickname

Date of Birth:_____ Gender:_____ SSN: _____

Mailing Address:_____

_____
CITY STATE ZIP

Primary Phone:_____ Secondary phone: _____

Work Phone:_____ Personal Email: _____

Marital Status: ☐ Single ☐ Life Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Declined

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American ☐ White ☐ Declined

Religion: _____ ☐ Declined

Ethnicity: Do you consider yourself to Hispanic or Latino? ☐ Yes ☐ No ■ Declined

Preferred Language: ☐ English ☐ Other (please specify):_____ _____

EMPLOYER:_____ Occupation:_____
Status: ☐ Part-time ☐ Full-time ☐ Self-employed ☐ Retired ☐ Active Military ☐ Disabled ☐ Student ☐ Unemployed

EMERGENCY CONTACT

Name:_____ Relation to Patient:_____
LAST FIRST

Home Phone:_____ Cell:_____

PARTY RESPONSIBLE FOR PAYMENT ☐ Check if same as patient

Name:_____ DOB:_____

Address:_____

_____
CITY STATE ZIP

Home Phone:_____ Cell:_____ Relation:_____

SIGNATURE_____ **DATE**_____
(Patient or Authorized Representative)

How did you hear about our practice?

☐ Referring Physician ☐ Online/Practice Website Family/Friend (Name)_____
Insurance Newspaper Television Other_____

PREFERRED TELEPHONE/MESSAGE & COMMUNICATION AUTHORIZATION

Mountain View Family Health Care, PC is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To assist us in protecting your privacy, please complete the following information:

Preferred number to contact you: _____ ☐ Home ☐ Cell ☐ Work

May we leave a voicemail if no answer? ☒ Yes ☐ No

May we discuss information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues: ☐ Yes ☒ No Medical Issues: ☐ Yes ☒ No

Please provide your email address if you would like to receive an invitation to our patient portal. Our portal allows you to message us, request refills, review records, and pay your bill, as well as several other things.
E-mail address _____

Name:_____ Phone: _____ Relationship to patient:_____

Name:_____ Phone: _____ Relationship to patient:_____

In the future, we may send text messages for appointment reminders or other communication to your cell phone.
Do you consent to this service? ◉ YES ○ NO

Patient Signature:_____ Date:_____

PLEASE COMPLETE IF PATIENT IS A MINOR (Less than 18 years old):

Age of minor:_____ Name of person completing form:_____
Please Print Relationship

If Parent of Legal Guardian is unavailable to accompany minor to appointment, please list authorized caretaker(s):

Name:_____
Please Print

Name:_____
Please Print

If minor is able to attend appointment unaccompanied, I agree to be financially responsible:

Parent or Legal Guardian Signature:_____ Date:_____

CONSENT AND AUTHORIZATIONS – Please initial each item.

_____**Consent for Health Care Services -** I authorize the healthcare providers, and/or their medical assistants to administer treatment as may be necessary or advisable in my diagnosis and treatment at Mountain View Family Health Care, PC. This authorization includes, but is not limited to, medical services, diagnostic procedures, medications, injections, laboratory services, and other services or procedures which my healthcare provider considers medically necessary. My health care provider will discuss with me the risks, benefits, and alternatives to recommended treatments. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered by the practice.

_____**Consent for Communication with Health Professionals and Pharmacies** – I authorize Mountain View Family Health Care, PC to obtain or provide information, as requested from other healthcare providers and pharmacies for the purpose of quality, continuity of care. I understand that Mountain View Family Health Care, PC may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law.

_____**Other Medical Services -** I understand that I may receive services from professionals who provide care for me that are not employees or agents of Mountain View Family Health Care, PC. These professionals may include other healthcare providers as requested by my health care provider to participate in my care such as radiology, pathology, and laboratory services. As a result, I understand that I may receive bills for these services that are separate from the bills I receive from Mountain View Family Health Care, PC. I understand that, in some cases, these professionals or facilities may not be participating providers under my insurance plan. I understand it is my responsibility to verify whether professionals providing my care are participating providers under my insurance, and that I may be responsible for any out of network costs incurred due to non-participation.

_____ **Insurance Participation –** I understand that I am responsible for verifying that Mountain View Family Health Care is a participating provider with my health insurance plan. If I have a plan that requires a PCP/HMO I understand that it is my responsibility to verify that any authorizations are in place prior to receiving services or understand that I will be financially responsible for services rendered.

_____ **Preauthorization Requirements -** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice and health care provider's charges, as well as charges recommend to me such as specialist consultation, MRI, CAT scan colonoscopy, etc. I also understand that my insurance may require an office visit with my primary health primary care provider prior to seeing a specialist. It is my responsibility to contact my insurance to verify the need for referral. If a referral or prior authorization is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit or procedure.

_____ **Assignment for Direct Payment -** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my providers. I understand that I am financially responsible to the practice or my providers for charges not covered or paid pursuant to this authorization.

_____ **Co-payment/Co-insurance –** I understand that all copayments or amount, as indicated by my insurance company are due the day services are rendered. I understand that there is a $10.00 statement billing charge for billing this co-payment if it is not paid within 24 hours of your appointment.

_____Financial Agreement – I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of the healthcare providers rendering services not otherwise paid by my health insurance or other payer. Estimated patient responsibility is due at the time of service. Any remaining charges are due upon receipt of the bill. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added.

_____**Collection Agency Assistance** – I understand that should I default on my account balance and collection agency services are initiated, I agree to pay all costs of collections; up to 45% of the balance, including attorney fees/court costs, which will be added to the balance of my account. This authorization shall remain in effect and may be applied to all future services rendered to me or my dependents for up to one year from the date of signing. This authorization may be withdrawn in writing before the one year has run, however the collection provision shall remain in effect for services already rendered and the Provider may refuse future medical care or services unless another agreement is signed allowing for collection fees and costs as set forth above.

_____ No-Show/No Cancellation policy – I understand that there **MAY** be a charge of $25.00 for my first missed appointment without 24-hours' notice and that a second missed appointment without 24 hours' notice **WILL** result in a $50.00, which must be paid prior to your appointment being rescheduled. Patients/families missing multiple appointments with less than 24 hours' notice will be dismissed from the practice. A small courtesy on your part allows us to schedule patients in your place rather than have to send them to an urgent care or remain on a waiting list.

_____ **Zero-Tolerance -** I understand that the healthcare providers and all staff at Mountain View Family Health Care deserve to be treated with respect and kindness while doing their job as directed by management, no matter what that job is. Cursing, threatening, demanding or otherwise intimidating or abusive actions or language will not be tolerated. This behavior will result in immediate dismissal from the practice.

_____ Acknowledgement of Notice of Privacy Practices – I acknowledge that Mountain View Family Health Care, PC has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Mountain View Family Health Care's website. I understand this acknowledgement in no way affects the care I shall receive at Mountain View Family Health Care, PC.

I have ○ ACCEPTED | ○ DECLINED a copy of the Notice of Privacy Practices.

I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE BEEN OFFERED COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

_____

Printed Name Signature Date

_____

Relationship to Patient