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 physician(s), nurse practitioner(s), their assistants and/or designees to administer any 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 physician or provider considers medically necessary. My health care provider will discuss with me the risks, benefits and alternatives to recommended treatments. 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. 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 health care providers and pharmacies for the purpose of quality, continuity of care.

_____**Other Medical Services -** I understand that I may receive services from professionals who provide care to me who are not employees or agents of Mountain View Family Health Care, PC. These professionals may include other health care 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.**

_____ **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's and physicians/nurse practitioners' 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.

_____**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 practice and of physicians/ nurse practitioners 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. If I default on my debt, I agree to pay all reasonable legal expenses necessary for the collection of any debt. **I consent to be contacted my regular mail, by email or by telephone (including a cell phone number) regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well, as to the use of technology including auto-dialing and/or prerecorded messages in contacting me.**

_____ **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.

SELECT ONE - 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 or REASON WHY PATIENT IS UNABLE TO SIGN IF OTHER THAN MINOR