High Mountain Medical P.C.

First Name: _____ M.I. _____ Last Name: _____

DOB: ___/___/____ SSN: _____ Marital Status: _____ Gender:_____

Home Address: _____ Zip Code:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email Address: _____

Insurance Information

Primary Insurance: _____ Member ID: _____

Guarantor Name: _____ DOB: _____ Relationship: _____

Secondary Insurance: _____ Member ID: _____

Guarantor Name: _____ DOB: _____ Relationship: _____

Other Information

Emergency Contact: _____ Phone #: _____ Relationship: _____

Pharmacy Name/Address: _____ Pharmacy Phone: _____

HIPAA

This is my authorization to allow VERBAL discussion of my condition, care, reminders of appointment times, test results, or other medical information to the following:

1. _____ Relationship: _____
2. _____ Relationship: _____

Print name: _____ Signature: _____

Please inform the office if you would like to add or remove someone Date: _____

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Chief Complaint

Describe the reason for your visit: _____

_____

_____

When did your symptoms begin? (select one)

_____Today _____ 3 months to 6 months

_____This week _____ 6 months to one year

_____Within last 3 months _____ More than one year

For Women Only: Most recent menstrual cycle: _____

Are you pregnant? Y N

Which word describes the frequency of your discomfort? (select one)

_____ Constant _____ Intermittent

_____ Occasional _____ Rare

Which phrases best describe changes in your discomfort during the day?

_____ It is worse in the morning _____ It is worse at night _____ doesn't change

_____ It is worse in the afternoon _____ changes with weather

What helps relieve your discomfort?

_____ Ice _____ Heat _____ Medication

_____ Other (please describe): _____

What activities are limited by your discomfort?

_____Bending _____ BM _____ Coughing _____ Daily Routine

_____ Driving _____ Getting Up _____Lifting _____ Lying Down

_____ Pulling _____ Pushing _____ Reading _____ Sitting

_____ Sleeping _____ Sneezing _____ Standing _____ Turning head

_____ Urination _____ Walking _____Working _____ Other

Where applicable, specify the approximate date of your most recent:

Physical Exam: _____ Dental X-Rays: _____

Spinal X-Ray: _____ CT Scan: _____

MRI: _____ Other Scans/X-Rays: _____

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Patient Name: _____ Date: _____

Health Questionnaire

Do you have an Advance Directive? Y N
Are you a victim of violence or abuse? Y N
Had a flu vaccine this year? Y N
Had a COVID vaccine? Y N
Name of Primary Care Provider:_____
Have you or members of your family recently been hospitalized for any reason? Y N

PLEASE INDICATE BELOW, ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:

General
Good general health: Y N
Recent weight change: Y N
Fever: Y N
Fatigue: Y N

Eyes and Vision
Eye disease or injury: Y N
Wear glasses/contacts: Y N
Blurred/Double vision: Y N
Glaucoma: Y N

Ears, Nose, Throat
Hearing Loss: Y N
Ringing in ears: Y N
Earaches or drainage: Y N
Sinus problems: Y N
Nose bleeds: Y N
Mouth sores: Y N
Bleeding gums: Y N
Bad breath/taste: Y N
Sore throat/ voice change: Y N
Swollen Glands: Y N

Heart and Cardiovascular
Heart trouble: Y N
Chest pains: Y N
Sudden heartbeat changes: Y N
Swelling of extremities: Y N

Respiratory
Frequent coughing: Y N
Spitting up blood: Y N
Shortness of breath: Y N
Asthma or wheezing: Y N

Gastrointestinal
Loss of appetite: Y N
Change in BM's: Y N
Nausea or vomiting: Y N
Frequent diarrhea: Y N
Painful BM's or constipation: Y N
Blood in stool: Y N

Musculoskeletal
Joint pain: Y N
Joint stiffness/swelling: Y N
Weakness of muscles/joints: Y N
Back pain: Y N
Cold extremities: Y N
Difficulty walking: Y N

Skin and Breasts
Rash or itching: Y N
Change in skin color: Y N
Change in hair or nails: Y N
Varicose veins: Y N
Breast pain: Y N
Breast lump: Y N
Breast discharge: Y N

Neurological
Frequent/recurrent headaches: Y N
Lightheaded or dizzy: Y N
Convulsions or seizures: Y N
Numbness or tingling: Y N
Tremors: Y N
Paralysis: Y N
Stroke: Y N
Head Injury: Y N

Psychiatric
Memory loss or confusion: Y N
Nervousness: Y N
Depression: Y N
Sleep problems: Y N

Endocrine
Glandular: Y N
Thyroid disease: Y N
Diabetes: Y N
Excessive thirst/urination: Y N
Heat or cold intolerance: Y N
Dry skin: Y N
Change in hat or glove size: Y N

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Stomach pain: Y N

Genitourinary

Frequent urination: Y N

Burning or painful urination: Y N

Blood in urine: Y N

Change in force/strain: Y N

Incontinence or dribbling: Y N

Kidney stones: Y N

Sexual difficulty: Y N

Painful/irregular periods: Y N

Hematologic/Lymphatic

Slow to heal after cuts: Y N

Easily bruise or bleed: Y N

Anemia: Y N

Phlebitis: Y N

Transfusion: Y N

Swollen glands: Y N

Last menstrual period: _____

Patient Signature: _____

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Authorization for Treatment, Release of information, Assignment of Benefits & Acknowledgement of Receipt of Notice of Privacy Practices & Consent for Treatment

PATIENT NAME:_____ DATE OF BIRTH:_____

Release of Information & Consent for Treatment

All information provided herein is true and correct. I am aware of my diagnosis and wish to receive treatment from **High Mountain Medical P.C.** and permit its employees and all other persons caring for me to treatment they judge are beneficial to me. I consent to services, and I understand, acknowledge and affirm that services may involve bodily contact and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.
I give permission to **High Mountain Medical P.C.** to release information, verbal and written, contained in my medical record, and other released information, to my insurance company, rehab curse, case manager, attorney, employer, school, related health care provider, assignees and/or beneficiaries, and all other relented person's as it relates to my treatment and/or payment for services provided. I authorize **High Mountain Medical P.C.** to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment the signature below certifies that I have read and understand the above information.

Initial_____

Assignment of Benefits

I authorize payment directly to **High Mountain Medical P.C.** for services and to bill and release payment directly to **High Mountain Medical P.C.** for any services provided, this is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial_____

Notice of Privacy Practices (HIPAA Acknowledgment/Consent)

I hereby acknowledge that I have been given the opportunity to receive and/or review the office Notice of Privacy Practices. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations.

Initial_____

Payment Guarantee

I agree to pay **High Mountain Medical P.C.** for the services provided to me or the party named above, if any law, such as Worker's Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer, where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for all account balances. The Intake Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage, I will be responsible for payment of services. I understand that my good faith payment may not be inclusive of all payments for which I am responsible, and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of **High Mountain Medical P.C.**

Initial_____

High Mountain Medical P.C.

ASSIGNMENT OF BENEFITS

Dear Patients,

As a patient of **High Mountain Medical P.C.**, we can accept your insurance for services performed. We will submit a claim for your treatment to your insurance company. While we are happy to provide this billing service to our patients, we do need your cooperation. By signing the assignment and release section below, you are authorizing your insurance company to send their payment directly to us instead of yourself. Should an insurance company send you a reimbursement check directly to you for services rendered here, you agree to send to us immediately after endorsing the back of the check as follows:

ENDORSEMENT: **Pay to the order of: High Mountain Medical P.C.**

Checks may be mailed to: **High Mountain Medical P.C.**
P.O. Box 945
Smithtown, NY 11787

ASSIGNMENT and RELEASE: I hereby assign to the care provider indicated above all rights, privilege, and remedies to payment for health care services provided by the assignee to which I am entitled under insurance law.

The assignee hereby certifies that they have not received any payment for or on behalf of the assignor (patient) and shall not purse payment directly from the assignor (patient) for the services provided by said assignee. Notwithstanding any prior written agreement to the contrary, this agreement may be revoked by the assignee when benefits are not payable based upon the assignor's (patient) lack of coverage and/or violation of policy condition due to the actions or conduct of the assignor (patient). I also authorize the release of any medical or other information necessary to process my claims.

Patient or Authorized Person(s):

Print:_____

Signature:_____

Date:_____