



HIGH MOUNTAIN HEALTH, P.A. Patient Registration Packet

Welcome to High Mountain Health.

We look forward to getting to know you and members of your family. We are committed to providing you not only high quality medical care for years to come, but also a new level of service that respects your lifestyle needs. We hope you will explore our Web site at www.HighMountainHealth.com for all the ways we do this, from our flexible appointment schedules, to our many locations, equipment and related services.

In the meantime, to help us get to know you better, please complete the five forms that are included in this packet. By completing these forms at home you will save time when you arrive for your appointment. The forms included below are:

1. Patient Registration
2. Patient Health History
3. Patient Medication List
4. Patient Record of Disclosure
5. High Mountain Health Financial Policy

If you have questions about any of the forms or need assistance from our staff, simply complete as much as you can at home and bring them with you. We will be more than happy to assist you.

Once again, thank you for choosing High Mountain Health as your partner in health.

Sincerely,

David V. Rasa, MD, R.Ph
President,
High Mountain Health



HIGH MOUNTAIN HEALTH, P.A. Patient Registration Form

Referred by: _____

Name: _____ S.S. Number: _____

Address: _____ Date of birth: _____

City/State: _____ Zip: _____ Home phone: _____

Parent/Guardian: _____ Cell phone: _____

Gender: ___ Male ___ Female Marital status: _____

Emergency Contact: _____ Phone No. _____

Employer Name: _____ Phone No. _____

Emp. Address: _____ City/State: _____

Patient's Occupation: _____

Primary Insurance: _____

ID No. _____ Group No. _____

Insured's Name: _____ Relation to Patient: _____

Subscriber's Employer: _____

Secondary Insurer: _____

Insured's Name: _____ Relation to Patient _____

Subscriber's Employer: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize High Mountain Health, PA, to apply for benefits on my behalf for covered services rendered by my family physician or by his/her order. I request that payment from my insurance company be made directly to High Mountain Health, PA (or to the party who accepts assignment),

I certify that the information I have reported with regard to my insurance coverage is correct.

I agree and accept the terms of the High Mountain Health's Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing,

Date: _____ Signature _____

(Patient/Guardian) _____



HIGH MOUNTAIN HEALTH, P.A. Patient Health History

Do you have a Living Will? Yes No Organ Donation Yes No

| | Father | Mother | Father's Parents | Mother's Parents | Siblings | Children |
|--|--------|--------|---------------------|---------------------|----------|----------|
| Heart Disease | | | | | | |
| High Blood Pressure | | | | | | |
| Stroke | | | | | | |
| Cancer | | | | | | |
| Glaucoma | | | | | | |
| Diabetes | | | | | | |
| Epilepsy/Convulsions | | | | | | |
| Bleeding Disorders | | | | | | |
| Kidney Disease | | | | | | |
| Thyroid Disease | | | | | | |
| Mental Illness | | | | | | |
| Other | | | | | | |
| History of Hospitalizations or Surgery | | | | | | |
| Reason | Date | Reason | Date | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Are you pregnant? Yes No Are you planning a pregnancy? Yes No

When was your last Tetanus shot? _____ Last MMR shot? _____

| Your Past Medical History – Circle any that apply | | |
|---|-------------------------|------------------------|
| Headaches | Gall bladder disease | Chronic Rashes |
| Shortness of Breath | Prostate disease | Rheumatic Fever |
| Heart palpitation | Bowel irregularity | GI disorder |
| Heart murmur | Menstrual dysfunction | Ulcers |
| Chest pain | Venereal disease (STDs) | Hepatitis |
| Dizziness or Fainting | Frequent infections | Gout |
| Peripheral vascular disease | Anemia | Asthma |
| Allergies/Hay fever | Arthritis | Bronchitis |
| Scarlet fever | Pneumonia | Depression |
| Insomnia | | |



HIGH MOUNTAIN HEALTH, P.A.

Patient Health History

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Do you smoke? Yes No If "Yes," how long have you smoked? _____

How much do you smoke? Packs per day

Do you have an exercise routine? If "Yes," describe your routine and indicate how many days per week you exercise _____

Do you drink coffee? Yes No If "Yes," how many cups daily? _____

Do you drink other beverages that contain caffeine? _____

Do you drink alcohol? Type _____. Approximate amount: _____

Do you use salt on a daily basis? Yes No If "Yes," how much? _____

Do you come into contact with blood, blood products or body fluids at work?

Yes No



HIGH MOUNTAIN HEALTH, P.A. Patient Record of Disclosure

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's work or cell phone instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
(Please check all that apply)

Home Phone: _____
 It is okay to leave message with detailed medical information
 It is NOT okay to leave a detailed message. Leave a call-back number only

Cell Phone: _____
 It is okay to leave message with detailed medical information
 It is NOT okay to leave a detailed message. Leave a call-back number only

Work Phone: _____
 It is okay to leave message with detailed medical information
 It is NOT okay to leave a detailed message. Leave a call-back number only

Emergency Contact: _____

Phone No. _____ Relationship: _____

Patient's Signature

Date

Print Name

Birthdate

FAMILY MEDICINE · URGENT CARE
PEDIATRICS · PHYSICAL THERAPY + SPORTS MEDICINE · COSMETIC SERVICES



FAMILY MEDICINE · URGENT CARE
PEDIATRICS · PHYSICAL THERAPY + SPORTS MEDICINE · COSMETIC SERVICES

Patient First Name: _____ **Date of Birth:** _____
Patient Last Name: _____ **Gender:** _____
Address: _____ **Home Phone:** _____

PATIENT FINANCIAL POLICY AGREEMENT

- I will present proof of identity and Insurance coverage at every visit.
- I understand it is my responsibility to be educated with the benefits and limitations of my Insurance policy.
- I understand my insurance policy is a contract between me and my insurance company. In the event they do not pay for services rendered to me which may include vaccinations, injections, and durable medical goods I am financially responsible for payment for those services.
- I understand that my account may be sent to a professional collection agency if payment is not rendered within 90 days from the billing date and in that event my relationship with High Mountain Health may be terminated.
- I understand that if I disagree with any charges or would like to request an adjustment be made on my invoice or claim, I must contact the billing office in writing within 30 days of the billing date.
- I understand that it is my responsibility to provide High Mountain Health with any information necessary to be paid for services rendered to me or anyone covered under my insurance policy or I will be responsible and will pay the balance in full.
- I understand, if I do not have proof of insurance, a deposit will be collected at registration and if there is a remaining balance it will be collected at the conclusion of the visit.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Print Name: _____

Signature of Patient or Responsible Party: _____ **Date:** _____

Wayne
246 Hamburg Tpk
Ph: 973.389.1800
Fax: 973.636.2734

Wayne
468 Parish Drive
Ph: 973.305.8300
Fax: 973.305.8157

North Haledon
535 High Mountain Rd
Ph: 973.636.9000
Fax: 973.636.0913

Oakland
19 Yawpo Ave
Ph: 201.337.3412
Fax: 201.337.3353

Little Falls
83 Long Hill Rd
Ph: 973.785.2440
Fax: 973.785.0141