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, simple 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

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

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

HIGH MOUNTAIN HEALTH, P.A.
Patient Medication List

Patient Name: ____

Allergies: ____

Name of Medication	Dose & Frequency	Start Date	Stop Date	Reason taking

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**

HIGH MOUNTAIN HEALTH, P.A.
Financial Policy

Thank you for choosing High Mountain Health as your health care provider. We are committed to quality care. The following is a statement of our Financial Policy that we require you read and sign prior to any services rendered.

- **Full payment is due at the time of service**
- **We accept cash and personal checks with a valid driver's license**
- **We offer an extended payment plan**
- **Usual and customary rates apply**

Our practice is committed to providing the best treatment of our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PREVENTIVE CARE
It is your responsibility to know your insurance benefits. Policies may or may not cover "well care," such as annual physicals, immunizations, sigmoidoscopy, mammography, and bone density screenings. You will be responsible for payment if such service is denied by your carrier.

ADULT PATIENTS: All adults are responsible for full payment at time of service.

MINOR PATIENTS: The adult (parent or guardian) accompanying a minor is responsible for full payment. In cases of divorce or separation, the parent accompanying the child is responsible for payment at time of service. We will provide you with a paid receipt.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

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

____
Print Name

____ ______________
Signature of Patient or Responsible Party **Date**