PREMIER
MOUNTAIN HEALTHCARE

*Co-pay:*_____
*Date:*_____

New Patient Registration

Patient Information

Name:_____DOB:_____
Sex: Male or Female SSN: _____ Marital Status:_____
Street Address:_____
City:_____ State:_____ Zip:_____
Home phone:_____ Cell phone:_____
Email: _____Would you like access to Patient Portal ( )Yes ( ) No
Preferred Method of Contact ( ) Cell Phone ( ) Home Phone ( )Text ( ) email
Okay to leave a detailed message ( ) Yes ( ) No
Prefered/Current Pharmacy_____Pharmacy Location:_____

Employer Information

Employer:_____ Work Phone:_____
Occupation:_____ Retired ( ) Yes ( ) No
Referred by:_____

Emergency Contact

Name:_____Relationship:_____
Home #: _____Cell #: _____Work # : _____
Consent to call emergency contact regarding medical care and test results ( ) Yes ( ) No
Name:_____Relationship:_____
Home #: _____Cell #: _____Work # : _____
Consent to call emergency contact regarding medical care and test results ( ) Yes ( ) No

Primary Insurance:

Policy Holder Relation: Self___Spouse___Parent___
Name of Policy Holder(if not self):_____DOB:_____SSN:_____
Insurance Policy Name:_____
Policy Number:_____Group Number:_____

Secondary Insurance:

Policy Holder Relation: Self___Spouse___Parent___
Name of Policy Holder(if not self):_____DOB:_____SSN:_____
Insurance Policy Name:_____
Policy Number:_____Group Number:_____

(Continue to Next Page)

Medical History

PAST CONDITIONS

Significant birth events: _____ Premature birth? ( ) Yes ( ) No

List all childhood illnesses:

_____

_____

List all Surgeries:

_____

_____

List all Injuries:

_____

_____

CURRENT CONDITIONS

Have you been diagnosed with any of the following (currently or in the past)?

__ Heart disease	__Kidney disease	__Stroke	__High Cholesterol
__ Seizure disorder	__Thyroid problem	__ Arthritis	__Diabetes
__ High Blood Pressure	__ Obesity	__Anemia	__Ulcers
__ Periodontal disease	__ Bone/joint problem	__Liver disease	__Cancer
__Cataracts	__Glaucoma	__Lung problem	__Depression

Other (list)_____

_____

List any other medical conditions you have(currently or in the past):_____

_____

Family History:

a. Write "F" for Father, "M" for Mother, or "S" for Sibling within the parentheses

( ) Heart disease	( ) Kidney problems	( ) Stroke	( ) Seizure disorder
( ) Cancer	( ) High blood pressure	( ) Diabetes	( ) Obesity
( ) Depression	( ) Schizophrenia	( ) Manic-depression	( ) Early Senility
( ) Alcoholism	( ) Other (list)_____		

_____

Allergies:

Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications:

Name	Dosage	Prescribing Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Supplements/ Alternative Remedies (vitamins, minerals, herbs, etc) you are taking:

Name Dosage

_____

_____

_____

_____

(Continue to Next Page)

List travel from the past two years:_____

Have you ever had a blood transfusion? __ Yes ___ No If Yes, when? _____

List any hospital admissions (include when, where and what condition):

_____

_____

_____

_____

Last Colonoscopy: _____ Any Abnormalities: _____

Last blood test done:_____Last cardiology work up or EKG performed:_____

FEMALES ONLY:

Are you Pregnant? ___ Yes ___ No Last Menstrual Period:_____

Number of Pregnancies: _____

Number of Live Births : _____ Vaginal _____ Cesarean_____ Number of Miscarriages: _____

GYN Surgery: _____

Last Pap Smear _____ Any Abnormalities? YES/ NO Comments: _____

Last Mammogram: _____ Any Abnormalities? YES/NO Comments: _____

Last Bone Density? _____ Any Abnormalities? YES/ NO Comments: _____

SOCIAL HISTORY:

Marital Status:

( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

School level completed? _____

Guns in the home? ( ) Yes ( ) No ( ) Locked in cabinet ( ) Bullets in separate place

Do you smoke or have your ever smoked? ( ) Yes ( ) No, if quit, when _____

Do you drink alcohol now? ( ) Yes ( ) No How much per week?_____

Did you drink alcohol in the past? ( ) Yes ( ) No ( ) Quit, When_____

Do you currently use illicit drugs? ( ) Yes ( ) No Type_____

Have you used illicit drugs in the past? ( ) Yes ( ) No

(Continue to Next Page)

REVIEW OF SYSTEMS: (Check any and all of the following you currently have)

( ) **None**

Constitutional

( ) Recent fever ( ) Recent weight loss ( ) Recent weight gain

Eyes

( ) Glaucoma ( ) Recent changes in vision

Ears, Nose, Mouth, Throat

( ) Frequent ear infections ( ) Frequent sore throats ( ) Frequent Sinus infections

Cardiovascular

( ) Chest pains ( ) Shortness of breath ( ) Palpitations

Respiratory

( ) Asthma ( ) Bronchitis ( ) COPD ( ) Pneumonia ( ) Pleurisy ( ) TB

Gastrointestinal

( ) Frequent indigestion/heartburn ( ) Vomiting ( ) Bloody/black stools ( )Diarrhea

Genito-Urinary

( ) Blood in urine ( ) Painful urination ( ) Kidney stones ( ) Incontinence

Musculoskeletal

( ) Frequent fractures/ sprains ( ) Arthritis ( ) Muscle aches ( ) Joint swelling

Integumentary

( ) Recent changes in skin

Neurological

( ) Headaches ( ) Seizures or convulsions ( ) Weakness ( ) Numbness

Psychiatric

( ) Treatment for psychiatric problems ( ) treatment for drug/alcohol dependency

Endocrine

( ) Decreased energy ( ) Dizziness ( ) Dry skin ( ) Hair loss

Hematologic/Lymphatic

( ) Easy bruising or bleeding

Allergic/Immunologic

( ) Severe allergic reactions to _____ ( ) Hay fever

Consent for Treatment

I certify that the above information is accurate, complete and true. I authorize Premier Mountain Healthcare and any associates, assistants, and other health care providers it may deem necessary, to treat my medical concerns;

- I voluntarily consent to any and all health care treatment and diagnostic procedures provided by PMH. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at PMH.
- I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the PMH of Privacy Practices.
- I authorize payment of medical benefits to PMH or their designee for services rendered
- I give permission to obtain all my medication/prescription history when using an electronic sstme to process prescriptions for my medical treatment.
- I have received a copy of the Notice of Privacy Practices

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
(SHORT FORM SUMMARY)
This Notice is Effective as of: 09/23/2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations: We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business. Marketing, Fundraising, and Sale of PHI: We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

Contact Us
Please inquire with any staff member should you have any questions, comments, or complaints; or to exercise any of your rights at Premier Mountain Healthcare.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I Acknowledge that I received and have read the Notice of Health Information Practices for Premier Mountain Healthcare. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Date

PRINTED Name of Patient or Responsible Party

_____

SIGNATURE of Patient or Responsible Party

_____

PREMIER

MOUNTAIN HEALTHCARE

The premier choice in healthcare you've been waiting for. Patient directed. Physician led.

Emergency Contact:

Name:_____Relationship:_____

Home #:_____Cell #:_____Work #:_____

Consent to call for an ( ) Emergency ( ) Medical Questions ( ) Both

Name:_____Relationship:_____

Home #:_____Cell#:_____Work #:_____

Consent to call for an ( ) Emergency ( ) Medical Question ( ) Both

Name:_____Relationship:_____

Home #:_____Cell#:_____Work #:_____

Consent to call for an ( ) Emergency ( ) Medical Question ( ) Both

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Signature:_____

Date: _____

PREMIER
MOUNTAIN HEALTHCARE

Medical Records Release

To ensure that your medical records are held in the utmost confidentiality, please be as explicit as possible as to where you want them sent.

Name_____ DOB _____
Address _____
Home Phone _____ Work Phone _____

Please Transfer my medical records as follows:
FROM:_____
_____
_____
_____

TO:
Premier Mountain Healthcare
5300 S. Sutter Dr. Suite A
Show Low, AZ 85901
Ph:928-251-4244
Fax: 833-539-1739

Records to be released:
___ All Medical Records
___ Labs/Xrays
___ Other _____

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV / AIDS) , and diagnosis of mental illness or psychiatric care cannot be released without my written consent.
Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

____ Drug and/or alcohol abuse, diagnosis or treatment
____ HIV/ AIDS testing and/or treatment
____ Psychiatric care and/or mental illness
____ Confirmed STD test results and/or treatment

This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 1 year>

_____
Signature
_____
Witness
_____
Interpreter, if needed
_____
Date

Provider
( ) Dr. Smithson
( ) Dr. Driss
( ) Dr. Bierer
( ) Mike Sassmann, PA
( ) Kim Hansen, NP
( ) Michele McCormick, NP
( ) Lyndsay Funk, NP

Financial Policy

Welcome and Thank you for choosing Premier Mountain Healthcare as your healthcare provider. We are committed to delivering the highest quality of care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all, of the services provided may be non-covered services that are not considered reasonable and necessary by your insurance carrier.

Participating Insurance Plans
For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file upon each visit. In the event that your insurance coverage changes to a plan with which we do not participate refer to the following paragraph.

Non Participating Insurance Plans
For those plans with which we do not participate - we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment(s) by cash or credit card/debit card are expected at the time of service. Your policy is a contract between you and your insurance company.

Minors
A minor must be accompanied by a guarantor for his/her account - with said parent/guardian of the minor or other adult accompanying the minor during each visit. An unaccompanied minor will be always be denied non-emergency treatment unless charges have been pre-authorized to an approved credit/insurance plan.

Authorization to pay Benefits to Physician/Office
I hereby assign payment directly to Premier Mountain Healthcare for medical and/or surgical benefits - if any - otherwise payable to me for services provided at the clinic...not to exceed my indebtedness to the clinic for those services. I understand that I am financially responsible for any charges for provided services not covered by my insurance, this includes charges that apply to co-insurance and/or deductible - said charges are due at the time of service.

Authorization to Release Information
I hereby authorize Premier Mountain Healthcare to release any information acquired in the course of my examination or treatment to my referring physician and/or my insurance company.

Account Balances
We will require that patients with outstanding balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the Office Manager with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Acknowledgement
I have read and understand the above Financial Policy and Benefit Authorization and agree to adhere to all provisions outlined herein.

_____

Patient Signature **Date**

Cancellation Fee Policy

Premier Mountain Healthcare is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. With that said - we understand that there are times when you must miss a scheduled appointment due to emergencies and/or obligations for work or family. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

Therefore, if you need to cancel and/or reschedule an appointment you are required to call no later than 24 hours prior to the scheduled appointment time. If you need to cancel/reschedule a Monday appointment - you must call prior to close of business on the Friday prior.

If an appointment is not cancelled at least 24 hours in advance of your schedule appointment time you will be charged a thirty-five dollar ($35) fee; this will not be covered by your insurance company and must be paid prior to your next appointment. Multiple Non-Cancellation/No-Show events in any given 6 month period may result in termination from our practice.

Patient Signature **Date**

Late Arrival Policy

Premier Mountain Healthcare understands that delays can happen - however, we must try to keep the other patients and doctors on time. If a patient arrives 10 minutes or more past their scheduled appointment time we will have to reschedule the appointment.

Patient Signature **Date**