MOUNTAIN VIEW
INTERNAL MEDICINE & PEDIATRICS

PATIENT REGISTRATION INFORMATION		Date:	
Patient Name (last, first, middle):			
Address:		City/State/Zip:	
Primary Phone #:		Alternate Phone#	
Employer/ School:		Email Address:	
Date of Birth:	Age:	Gender:	Marital Status:
Social Security #:	How did you hear about us?		
Race:		Ethnicity:	
Emergency Contact Name:		Relationship:	Phone #:

INSURANCE & BILLING INFORMATION			
Primary Insurance Name:	ID #:	Group #:	
Policy Holder's Name:	Address/ City/ State/ Zip:		
Policy Holder's Relationship:	Policy Holder's SSN:	Policy Holder's DOB:	
Responsible Party's Name:	Address/City/State/Zip:		
Relationship:	DOB:	SSN:	Phone #:

General Consent & Financial Policies

I consent to medical care at Mountain View Internal Medicine & Pediatrics. I am aware that healthcare is not an exact science. No guarantees have been made.

Financial Responsibility: **I understand that all co-pays and deductibles are to be paid at the time of service.** I agree to pay for **ALL** medical services provided. I understand that I may need to call my insurance company to see if they will approve and pay for the medical care. Please bill my health insurance plan as a service to me. I am aware that this does not mean that they will agree to pay for any services. I agree to pay whatever amount is not covered. I assign all of my rights and claims for payment under any health insurance plan to Mountain View Internal Medicine & Pediatrics. I appoint Mountain View Internal Medicine & Pediatrics or their agents as my "authorized representative" to act for me in getting payment for services provided. If I pay more than what I owe I agree that it can be used to pay for any unpaid bills I have. I give permission to be contacted for treatment or payment purposes via any of the telephone numbers or email addresses I have given. This includes contact with a pre-recorded message, automatic dialing system, artificial voice, email message, or text message. Contact may also be made by businesses helping my providers collect money that I owe.

I understand and agree with the above information.

_____ _____

Signature Date

7051 Heathcote Village Way, Suite 155 · Gainesville, VA 20155 · Ph (571) 248-0167 · Fax (571) 248-0173
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ADULT HEALTH HISTORY

Name _____ _____ _____
Last First Middle

Age ____ Date of Birth _____ Date of last physical exam _____

What is the reason for today's visit _____

SYMPTOMS – Check (✓) symptoms you currently have or have had in the past year

GENERAL
___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Forgetfulness
___ Headaches
___ Loss of Sleep
___ Loss of weight
___ Nervousness
___ Numbness
___ Sweats

MUSCLE\JOINT\BONE
Pain, weakness, numbness in:
___ Arms ___ Hips
___ Back ___ Legs
___ Feet ___ Neck
___ Hands ___ Shoulders

GENITO-URINARY
___ Blood in urine
___ Frequent urination
___ Lack of bladder control
___ Painful urination

GASTROINTESTINAL
___ Appetite poor
___ Bloating
___ Bowel Changes
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gas
___ Hemorrhoids
___ Rectal bleeding
___ Stomach pain
___ Vomiting
___ Vomiting blood

CARDIOVASCULAR
___ Chest pain
___ High blood pressure
___ Irregular heart beat
___ Low blood pressure
___ Rapid heart beat
___ Poor circulation
___ Swelling of ankles
___ Varicose veins

EYE, EAR, NOSE, THROAT
___ Bleeding gums
___ Blurred Vision
___ Crossed eyed
___ Difficulty swallowing
___ Double Vision
___ Earache
___ Ear discharge
___ Hay Fever
___ Hoarseness
___ Loss of hearing
___ Nosebleeds
___ Persistent cough
___ Ringing in the ear
___ Sinus problems
___ Vision – Flashes
___ Vision – Halos

SKIN
___ Bruise easily
___ Hives
___ Itching
___ Changes in moles
___ Rash
___ Scars
___ Sore that won't heal

MEN ONLY
___ Breast lump
___ Erection difficulties
___ Lump in testicles
___ Penis discharge
___ Sore on penis
___ Other

WOMEN ONLY
___ Abnormal Pap Smear
___ Bleeding between periods
___ Breast lump
___ Extreme menstrual pain
___ Hot flashes
___ Nipple discharge
___ Painful intercourse
___ Vaginal discharge
___ Other
Date of last
Menstrual period _____
Date of last
Pap Smear _____
Have you had
a mammogram? _____
Are you pregnant? _____
Number of children _____

CONDITIONS – Check (✓) diagnoses you currently have or have had in the **past year**

___ AIDS
___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding disorders
___ Breast lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Chicken Pox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herpes
___ High Cholesterol
___ HIV positive
___ Kidney disease
___ Liver disease
___ Measles
___ Migraine headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Psychosocial Issues
___ Pneumonia
___ Polio
___ Prostate problems
___ Psychiatric care
___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Suicide attempt
___ Thyroid problems
___ Tonsillitis
___ Tuberculosis
___ Ulcers
___ Vaginal infections
___ Venereal disease

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FAMILY HEALTH HISTORY – Fill in health information about your immediate family.

Relation	Age	State of Health	Age of Death	Cause of Death	Check (✓) if, your blood relatives had any of the following. Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	
					Other	

HOSPITIZATIONS

Year	Hospital	Reason for Hospitalization and outcome

Have you ever had a blood transfusion? ____ Yes ____No

If yes, please give approximate dates _____

SERIOUS ILLNESS\INJURIES	DATE	

PREGNANCY HISTORY

Year of birth	Sex of birth	Complications, if any

HEALTH HABITS – check (✓) which substances you use and describe how much you use:

	Exercise	
	Diet	
	Caffeine	
	Tobacco	
	Alcohol	
	Street Drugs	
	Other	

MEDICATIONS – List medications you are currently taking	**ALLERGIES** (medications or substances)

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E-PRESCRIBING CONSENT FORM

ePrescribing is defined by a Physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

Formulary and benefit transactions - gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that ***Mountain View Internal Medicine & Pediatrics*** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to ***Mountain View Internal Medicine & Pediatrics*** to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

This consent will remain enforce until revoked or changed.

_____

Patient Name (PLEASE PRINT)

_____ _____

Signature Date

Relationship to Patient: _____

Pharmacy (Name & Location) _____

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION to MVIMP

Patient's Name: _____Date of Birth:_____

Previous Name: _____Social Security#: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: Mountain View Internal Medicine & Pediatrics, Inc.

Address: 7051 Heathcote Village Way Suite 155

City: Gainesville, VA 20155 Fax: 571-248-0173

This request and authorization applies to:

□ All healthcare information

□ Healthcare information relating to the following treatment, condition, or dates:

_____

□ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

□Yes □No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□Yes □No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

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PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I.Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient _____ **Date of Birth** _____ **Signature of Patient/Parent/Guardian** _____

Today's Date: _____

II.Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:
I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: _____ **Last four digits of SSN or other identifier:** _____
Print Name: _____ **Last four digits of SSN or other identifier:** _____
Print Name: _____ **Last four digits of SSN or other identifier:** _____

III.Request to Receive Confidential Communications by Alternative Means:
As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number: _____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Written Communication Address: _____
____ OK to mail to address listed above
____ E-mail me at:_____

Work Telephone Number: _____
____ OK to leave message with detailed information
____ Leave message with call back numbers only

Fax Communication: _____
____ OK to Fax at the number listed above
____ E-mail me at:_____

Other:_____

IV.The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Print Name: _____ **Print Name:**_____
Print Name: _____ **Print Name:**_____

V.The HIPAA Privacy rule requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI. I understand that this accounting will not reflect disclosures that are made in the course of the Practice's ordinary health care activities related to providing patient treatment, obtaining payment for its services or its internal operations. Also, the Practice does not have to account for disclosures for which I have executed an Authorization permitting disclosures of my PHI.

Date of disclosure request	Disclosed to whom: address/fax	Description of disclosure	Purpose of disclosure	Dates of Service of disclosure	Person completing request	Date completed

1. The above authorizations are voluntary and I may refuse to agree to their terms without affecting any of my rights to receive healthcare at the Practice.

2. These Authorizations may be revoked at any time by notifying the Practice in writing at the Practices mailing address marked to the attention of "HIPAA Compliance Officer."

3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.

4. I may see and copy the information described in this form, if I ask for it, and I will get a copy of this form after I sign it.

5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction, that I fully understand this authorization form, and have received an executed copy.

6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____

Name of Patient (Printed) Signature of Patient Date

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2020 Annual Fee Payment (eff. 11/1/2019)

Includes: Completion of Work or School Forms
Letter for Workplace or Insurances
Mailing Letters of Copies of Labs or Study Results
Processing Referrals
Prior Authorization Requests for Prescriptions
Transferring Records to another Physician

(administrative fees, electronic communication, postage, form completion, and other services which incur expenses over and above the traditional "office visit" cost)

Last Name, First Name_____
Family Members *also current patients*_____

Check one:

- **Individual:** $20.00
- **Two patients:** $40.00
- **Family Option**: $50.00 (Multiple siblings, or combined parents and dependent children)

I, the undersigned, **agree to pay** Mountain View Internal Medicine & Pediatrics an annual fee (one time per year, not per office visit) for "non-covered" services which include listed above. **I understand that this fee does not apply to insurance co-pays, deductibles or the cover charges for missed appointments.**

Signature Date

I, the undersigned, **elect not to pay** Mountain View Internal Medicine & Pediatrics' annual Administration fee. I understand that if I elect not to pay this fee; I will pay for additional services as I need them according to the schedule of fees provided to me.

Signature Date

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