



Welcome to Mountain View Medical Center

Thank you for considering Mountain View to partner with on your health journey. In addition to reading through and filling out this new patient packet, we also want to make you aware of some responsibilities that you, as a patient, have in regards to your medical benefits and receiving care at our clinic.

As a courtesy, we are happy to bill your medical insurance carrier for services that you receive at our clinic. However, due to the amount of plans each insurance has, we cannot guarantee that we are in network with your specific plan. It is up to you to contact your insurance carrier and verify the health benefits covered by your specific insurance plan. This will prevent an unexpected increased copay, deductible, or co-insurance amount that you may be responsible to pay. Below you will find a list of questions that will be helpful when determining possible financial responsibility for you.

Please call the member or customer service phone number that is typically listed on the back of your insurance card and ask:

- Is the provider I am scheduled to see IN NETWORK with your insurance plan?
- Do I have a deductible? If so, what is the amount?
- Do I have a copay? Is it for both preventative and non-preventative visits?
- Does my plan cover lab services by Quest Diagnostics or do I need to be sent to a different lab?

Deductible: the amount the insured person pays before the insurance company pays

Copay: the amount the insured person pays at the time of the appointment

Coinsurance: the percentage the insured person pays after deductible and copy have been paid OR the percentage of the medical bill the insured person is responsible to pay

If you have any questions you may call our billing team, while they cannot assist you with the parameters of your individual plan they can give additional guidance regarding what to ask your insurance carrier.

Thank you for the opportunity to continue to partner with you on your overall health journey. We look forward to meeting you!

- Mountain View Medical Center



Mountain View Medical Center
Demographic Sheet

PATIENT INFORMATION

Name: Date of Birth: Sex: [] Male [] Female
Address: Gender Identity: Pronouns:
City, State, Zip: Social Security #:
Phone: [] Home [] Work [] Other Marital Status: [] Married [] Single [] Divorced
Preferred Language:
Ethnicity: [] Hispanic or Latino [] Non-Hispanic or Latino [] Other
Race: [] American Indian or Alaska Native [] Asian [] Black or African American [] Native Hawaiian or Other Pacific Islander
[] White or Caucasian [] Other or Undetermined

PATIENT EMPLOYMENT INFORMATION

[] Employed [] Retired [] Unemployed [] Other
Employer's Name:
Employer's Phone:
Occupation:

EMERGENCY CONTACTS

Name Relationship Phone

RESPONSIBLE PARTY

(if patient is under 18 years of age)

Name: Employer:
Address: Home Phone:
City, State, Zip: Work Phone:
Social Security #:
Date of Birth:

PRIMARY INSURANCE

Insurance Co. Name:
ID #:
Group/Policy ID #:
Subscriber's Name:
Subscriber's DOB:

SECONDARY INSURANCE

Insurance Co. Name:
ID #:
Group/Policy #:
Subscriber's Name:
Relationship to Patient:

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid for by my insurance. I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

PATIENT/GUARDIAN SIGNATURE

DATE



Acknowledgement and Consent

I understand that Mountain View Medical Center (referred to below as “This Practice”) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by This Practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment; refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative, and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice’s Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By: _____

Date: _____

Patient or Guardian Signature



Patient's Responsibility for Payment

As a service to our patients, Mountain View Medical Center (MVMC), will submit charges for medical treatment to the patient's insurance company, where applicable, and to Medicare. However, **the patient is primarily responsible for paying any and all medical expenses incurred at the clinic.** If you do not have any medical insurance, you will be responsible for the bill at the time of service. Monthly statements will be sent when there is a patient balance and payment is expected on a regular basis.

MVMC may attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.

If the patient participates in an HMO or PPO that requires co-payment, the patient MUST pay the co-payment at the time of the appointment or a \$20 fee will be assessed in addition to the co-payment.

Subject to additional fees:

- Insurance claims resubmission due to inaccurate/incomplete info provided by patients is \$25
- Returned checks for insufficient fund NSF is \$35 plus amount of check
- Each and all no show appointments (A 24 hour cancellation policy is in effect) is \$50
 - Arrival 7 minutes after appointment time may result in required rescheduling of appointment and may also be considered a no-show or failed appointment in which a fee can be incurred.

If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs, even if there is a pending lawsuit.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at MVMC for medical care and treatment. I agree to pay all medical expenses within 90 days from the date of service, unless other arrangements have been made with MVMC. I understand that any bill 90 days overdue will be sent to collections and MVMC will withdraw from care at that time.

I authorize release of all my medical information to my insurance company and I authorize payment of all medical benefits by my insurance company to MVMC.

Signature: _____ Date: _____

Patient or Guardian Signature

MARRIAGE AND SEXUALITY

What is your relationship status? Married Single Divorced Separated Widowed Domestic Partner Other
 Are you sexually active? Yes No
 Do you have future plans to get pregnant? Yes No Unsure
 How many children do you have? ____
 Do you want to talk about contraception or pregnancy during your visit today? Yes No

LIFESTYLE

Do you use your seat belt or car seat routinely? Yes No

DIET AND EXERCISE

What is your exercise level? None Occasional Moderate Heavy
 How many times a week do you exercise? <1 time/week 1-2 times/week 3-4 times/week 5-7 times/week
 How many days of moderate to strenuous exercise did you do in the last week? ____
 What type of sporting activities do you participate in? _____

HOME AND ENVIRONMENT

Are you passively exposed to smoke? Yes No
 Are there any smokers in your house? Yes No

PAST MEDICAL HISTORY- Check conditions that you have had in the past

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> GI Problems | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Muscle, Joint, Bone |
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Nervous system Disorder |
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neurologic Disorder |
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Abuse/Domestic Violence | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Attack (MI) | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Congenital Anomalies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemochromatosis | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polyps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Pre-eclampsia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dementia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> Hospital Admission | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Developmental Disorders | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Thrombophilia |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder or Kidney Problems | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Diseases | <input type="checkbox"/> Ear or Hearing Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Varicosities |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Edema | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Vision/Eye Problems |
| <input type="checkbox"/> Breast Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> MRSA Exposure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Meniere's Disease | |
| <input type="checkbox"/> CRF | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mental Disorder | |

SURGICAL HISTORY

When was the date of your last colonoscopy? _____

Please list all past surgeries:	Doctor or location:	Date

FAMILY HISTORY- List blood relatives with the following problems including Mother, Father, Sister, and Brother

Problem:	Relative:	Age at Onset:

GYNECOLOGY/OBSTETRIC HISTORY

At what age did you start your periods? _____

Still having periods? Yes No

If post-menopausal, age at menopause? _____

Do you have periods monthly? Yes No

How much time between your periods? _____

Duration of flow (days) _____

How is your menstrual flow? Light Moderate Heavy

Date of last menstrual period _____

Date of last Pap smear _____

Date of most recent mammogram _____

Have you had the HPV vaccine? Yes No

Have you ever had an abnormal pap? Yes No

Are you sexually active? Yes No

What type of contraception (birth control) do you use?

Do you have any sexual problems? Yes No

Do you have any HIV risk factors? Yes No

STIs or STDs? Yes No

At what age did you have your first child? _____ N/A

Were you on birth control pills at conception? Yes No

of times have you been pregnant? _____

of full term pregnancies? _____

of premature births? _____

of induced abortions? _____

of miscarriages? _____

of ectopic pregnancies? _____

of multiple births? _____

of live births? _____

Mountain View Medical Center

AUDIT

PatientName: _____
Date of Birth: _____

Alcohol: One drink = 12oz. beer 5oz. wine 1.5 oz. liquor (one shot)

(Circle your answer.)

1.	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2.	How many standard drinks containing alcohol do you have on a typical day when drinking?	0	1 or 2	3 or 4	5 or 6	7 to 9	10+
3.	How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4.	During the past year, how often have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5.	During the past year, how often have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6.	During the past year how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7.	During the past year, how often have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8.	During the past year, have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9.	Have you or someone else been injured because of your drinking?	No		Yes, but not in past year		Yes, in past year	
10.	Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in past year		Yes, in past year	

Depression:

During the last 2 weeks, how often have you been bothered by any of the following problems?
(Circle your answer.)

- | | | | | |
|--|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | Not at all | Several days | More than half the days | Nearly every day |
| 2. Feeling down, depressed or hopeless | Not at all | Several days | More than half the days | Nearly every day |



***If answer to above questions is “Not at all” please continue to next page**

- | | | | | |
|--|----------------------|--------------------|-------------------------|---------------------|
| 3. Trouble falling/staying asleep, or sleeping too much | Not at all | Several days | More than half the days | Nearly every day |
| 4. Feeling tired or having little energy | Not at all | Several days | More than half the days | Nearly every day |
| 5. Poor appetite or overeating | Not at all | Several days | More than half the days | Nearly every day |
| 6. Feeling bad about yourself or that you are a failure or have let yourself or your family down | Not at all | Several days | More than half the days | Nearly every day |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | Not at all | Several days | More than half the days | Nearly every day |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual | Not at all | Several days | More than half the days | Nearly every day |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | Not at all | Several days | More than half the days | Nearly every day |
| 10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

1 or more None

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?



***If answer is “none” please continue to next page.**

Which of the following drugs have you used in the past year?

- | | |
|---|---|
| <input type="checkbox"/> methamphetamines (speed, crystal) | <input type="checkbox"/> cocaine |
| <input type="checkbox"/> cannabis (marijuana, pot) | <input type="checkbox"/> narcotics (heroin, oxycodone, methadone, etc.) |
| <input type="checkbox"/> inhalants (paint thinner, aerosol, glue) | <input type="checkbox"/> hallucinogens (LSD, mushrooms) |
| <input type="checkbox"/> tranquilizers (valium) | <input type="checkbox"/> other _____ |

How often have you used these drugs? Monthly or less Weekly Daily or almost daily

- | | | |
|--|----|-----|
| 1. Have you used drugs other than those required for medical reasons? | No | Yes |
| 2. Do you abuse more than one drug at a time? | No | Yes |
| 3. Are you always able to stop using drugs when you want to? | No | Yes |
| 4. Have you ever had blackouts or flashbacks as a result of drug use? | No | Yes |
| 5. Do you ever feel bad or guilty about your drug use? | No | Yes |
| 6. Does your spouse (or parents) ever complain about your involvement with drugs? | No | Yes |
| 7. Have you neglected your family because of your use of drugs? | No | Yes |
| 8. Have you engaged in illegal activities in order to obtain drugs? | No | Yes |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | No | Yes |
| 10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? | No | Yes |

Have you ever injected drugs? Never Yes, in the past 90 days Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? Never Currently In the past

Health-Related Social Needs Screening



Name: _____ DOB: _____

LIVING SITUATION

1. What is your living situation today? (Z59.XX)

I have a steady place to live

I have a place to live today, but I am worried about losing it in the future (Z59.811)

I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. **Think about the place you live. Do you have problems with any of the following? (Z59.XX)**

CHOOSE ALL THAT APPLY

Pests such as bugs, ants, or mice

Yes No

Oven or stove not working

Yes No

Mold

Yes No

Smoke detectors missing or not working

Yes No

Lead paint or pipes

Yes No

Water leaks

Yes No

Lack of heat

Yes No

None of the above

FOOD (Z59.4X)

Some people have made the following statement about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.

3. Within the past 12 months, you worried that your food would run out before you got money for more.

Often True

Sometimes true

Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Often True

Sometimes true

Never true

Transportation (Z59.82)

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

Yes

No

Utilities (Z59.12)

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes

No

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

7. How often does anyone, including family and friends, physically hurt you?

Never

Rarely

Sometimes

Fairly often

Frequently

8. How often does anyone, including family and friends, insult or talk down to you?

Never

Rarely

Sometimes

Fairly often

Frequently

9. How often does anyone, including family and friends, threaten you with harm?

Never

Rarely

Sometimes

Fairly often

Frequently

10. How often does anyone, including family and friends, scream or curse at you?

Never

Rarely

Sometimes

Fairly often

Frequently