Mtn
Medical

"Health care you deserve!"

NEW PATIENT Request

PLEASE INDICATE IF YOU ARE TAKING ANY NARCOTICS

_____YES

_____NO

*****WE DO NOT PRESCRIBE THE FOLLOWING*****
Clozipine, Ativan, Lorazepam, Clonazepam, Xanax, Lortab, Hydrocodone, Norco, Tramadol, Methadone, Oxycodone, Tylenol # 3 or 4, Oxycontin, Oxymorphone, Suboxone, Subtex, Adderall, Amphetamine Salt, Concerta, Vyvanse, or Ritalin

***** Please include a copy of your Photo ID & Insurance Card*****

Office Use Only:

Demographics: _____

History: _____

Mountain Medical Policies & Guidelines

Mountain Medical Services Guidelines

in order to meet your expectations, we would like to communicate Mountain Medical guidelines (Mountain Medical reserves the right to make necessary changes to guidelines as deemed necessary):

24-hour change notice is requested on all appointments
For all missed appointments, a $25.00 charge may be incurred by patient
Missed appointments may be charged at Mountain Medical's discretion
If you are more than 15 minutes late for an appointment, you may be asked to reschedule.
If you are under the age of 18, you **MUST** be accompanied by a legal guardian in order to been seen.
Your patient rights entitle you to receive ONE FREE COPY of your medical records. You may be charged our standard medical records fee for any additional requests.
Payment is due when services are rendered.
If patient account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee may be added to the outstanding balance and will be turned over to collections for further procession. No additional appointments will be made for delinquent accounts until they are brought current.
There may be a charge for telephone calls at provider's discretion based on nature and length. You will be informed at that time of any charges.
After-hours visits (after 5:00pm) and weekend visits will be provided at a surcharge of $25.00 in addition to co-pay / co-insurance charges.
Telephone calls will be returned at the discretion of each provider unless there is an emergency requiring immediate attention. If immediate attention is required, please let the staff know the urgency of the message.
(3) THREE-Business Day NOTIFICATION is requested on all prescription refills.
Please bring a current insurance card with you to every visit along with a photo ID.
It is the patient responsibility to notify Mountain Medical of ANY INSURANCE, policy changes or demographical changes before services are rendered.
Mountain Medical reserves the right to perform drug screens on patients that are obtaining prescription medication that is considered a scheduled narcotic (please ask the front desk, talk to your pharmacist or contact the DEA for a complete listing of scheduled drug classes).
Mountain Medical reserves the right to random drug screen any patient at the discretion of the provider
Mountain Medical DOES NOT PRESCRIBE NARCOTICS for long term chronic conditions.

I acknowledge that a copy of the Mountain Medical Services, PLLC Office Policies & Guidelines were available to me during my office visit and it my responsibility to read, understand, and adhere to these policies.

_____	_____	_____
Patient Name (PRINT NAME)	Patient Signature	Date

Financial Policy Effective May 1, 2015

Thank you for choosing Mountain Medical Services, PLLC as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.
2. _____ I understand that Mountain Medical Services, PLLC will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Mountain Medical Services, PLLC. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.
3. _____ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier's check, money order, or cash.)
4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Mountain Medical Services, PLLC at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.
5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.
6. _____ Mountain Medical Services, PLLC will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Mountain Medical Services, PLLC if there is any change in my insurance coverage, residence, or phone number. **ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.**

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Mountain Medical Services, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges where or not paid by said insurance.** I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party: _____ Date:_____

Patient Registration Form

Mtn Medical

Patient Information

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:		Apt #	
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Please Select Preferred Number: ☐ Home ☐ Cell ☐ Work		**Can we leave a message regarding your medical care & test results?** ☐ Yes ☐ No	
Family Physician or Pediatrician:	Date of Birth:	Sex: ❑ Male ❑ Female	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		
City/State/Zip:	Relationship to Patient:	

Additional Information **(PLEASE FILL OUT ALL SECTIONS BELOW)**

Email Address:

Race (please select):

☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Mountain Medical Services payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to Mountain Medical all money to which I am entitled for medical expenses related to the services performed from time to time by Mountain Medical, but not to exceed my indebtedness to Mountain Medical. I authorize Mountain Medical to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Mountain Medical by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to Mountain Medical. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Mountain Medical Service's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: X _____ **Date:** _____

Printed Name of Responsible Party: X _____ **Date:** _____

Mtn Medical

PATIENT INFORMATION SHEET

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

HIPAA

Patient Name:_____ DOB_____

☐ I authorize phone messages to be left with the phone number on my patient account

☐ I do NOT authorize the release of any information.

☐ I authorize the release of my information to the following

Name:_____ Relationship to patient:_____
Phone Number: _____

Name:_____ Relationship to patient:_____
Phone Number: _____

Please check all that apply:

☐ Medical records and visit details

☐ Appointment date and time information

☐ Billing information

☐ All Records

_____ _____
Patient/Guardian Signature Date

*** A printed copy of our HIPAA policy is available at request***

Mountain Medical Services, PLLC
2946 Winfield Dunn Parkway, Suite 107, Kodak, TN 37764
Phone: (865)933-9950 Fax: (865)465-3937
www.mountainmedicaltn.com

Mtn Medical

2946 Winfield Dunn Pkwy Suite 107, Kodak, TN 37764
Office 865-933-9950 Fax 865-465-3937
Dr. Roger Barnes Amy Jarrett, FNP

Medical Records Release/Request Form

(*Check One*)

Release_____ Release of information from Mtn Medical to an individual or to your provider.

*Release _____ Release of information from Mtn Medical to myself.

Request_____ Request that information from another provider be released to Mtn Medical.

Date:_____ Patient Name: _____ Date of Birth:_____
Address: _____
Phone: _____ Social Security # _____

I authorize **Mtn Medical Services** to (*Mark One*) _____Release/ _____Request the following:

Information Requested: _____ All Records _____Labs Only _____H&P
_____Other:_____

Purpose of Request: _____ Change of Physician _____ Insurance Related
_____Other: _____

Duration of Authorization: _____ _____Days _____Weeks _____Months

To/From (*circle one*) Name:_____
Address: _____
Phone:_____ Fax:_____

(It is important that you give as much contact information as you can, especially the provider's name and phone.)

- I understand that this authorization shall be valid through (date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be u nable to provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

_____ _____
Signature Date

_____ _____
Witnessed by Date