Mountain Medical

Last Name: _____ First Name: _____ DOB: _____

Legal Sex: _____ Home Phone: _____ Mobile: _____ Preferred Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Email address: _____

If patient is a child who is filling out this form: _____

Relationship to patient: _____

Personal Information

Preferred Language: _____Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline

Race: White Asian Native Hawaiian-Pacific Islander Black-African American American Indian-Alaskan Native

Other _____

Smoking: (Circle One) Current : Frequency _____ Former Never Decline

Height: _____ Weight: _____

Medical Insurance / Workers Comp / Auto Plan

Primary Insurance Plan Name: _____

ID #:_____ Group Number: _____

Guarantor Name: _____ DOB: _____ Employer: _____

Secondary Insurance Plan Name: _____

ID #:_____ Group Number: _____

Guarantor Name: _____ DOB: _____ Employer: _____

Tertiary Insurance Plan Name: _____

ID #:_____ Group Number: _____

Workers Comp / Auto Plan Name: _____ Phone #: _____

Address: _____ Employer: _____

Case #:_____ Case Worker: _____

Emergency Contact

Name: _____ Phone #: _____

Relationship to patient: _____

Authorization of Medical Release

I authorize Mountain Medical to discuss or send my medical information to the following person/people:

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Referring Physician: _____

Financial Agreement

Mountain Medical believes communication is key in excellent customer service. We will always communicate with you via telephone, email, and or text messages through the number and email associated with your account.

Understand that all applicable copayments and deductibles are due at the time of service. You agree to be financially responsible and make full payment for all charges not covered by your insurance company. You authorize your insurance benefits be paid directly to Mountain Medical Imaging for services rendered. You authorize representatives of Mountain Medical Imaging to release pertinent medical information to your insurance company when requested to facilitate payment of a claim.

We at Mountain Medical wish to resolve all payment issues with you in a quick and acceptable manner. However, if your account must be sent on to a 3rd party collections company you will be responsible for a 30% additional collections fee as well as any interest and legal fees applied by the collection agency.

Signature: _____ Date: _____

Relationship if other than patient: _____ Print Name: _____

We offer 2 options for payment of today's services. Please choose one:

_____**Bill my insurance.** I understand that I am responsible for any co-pay or co-insurance that my insurance company leaves to my responsibility. I understand that by choosing this option, I forego my opportunity to utilize Mountain Medical's self-pay rates.

_____**Utilize Mountain Medical's self-pay rates.** This discounted rate is offered to those choosing not to bill insurance. I understand that the amount paid will not go toward my insurance deductible. I understand that I cannot bill my health insurance, Mountain Medical will not bill my health insurance after the date of service, and I am fully financially responsible.

Signature: _____ Date: _____

Relationship if other than patient: _____ Print Name: _____

HIPAA Notice

I _____have received, read and understand the Mountain Medical HIPAA practices notice.

Signature: _____ Date: _____