ROCKY MOUNTAIN
Health&Wellness

Dear Patient,

Thank you for taking the time to fill out the following new patient forms before your first visit. If possible, at least one week prior to your appointment, return the completed forms to our office. This will ensure that you are seen as quickly as possible after you've walked through our front doors. I hope it will make our time together more efficient and productive. If you prefer you may email or fax us your new paperwork in advance to expedite the process. As a reminder, please bring the following with you to your appointment:

- Completed new patient forms. Please be as detailed and accurate as possible when filling out the forms.
- A copy of any blood (lab) work that has been done in the past year. Your provider/practitioners office may fax this directly to us. Fax: 208-938-5679
- If you take nutritional supplements, please bring your bottles with you to your appointment.
- Your insurance card or a copy of the front and back of your insurance card.
- Credit card, check, or cash for your insurance co-payment.
- Driver's License

No Show Policy --- We require a 24-hour cancellation notice for all scheduled appointments no kept or you may be charged a $75.00 fee for that missed appointment. Insurance does not cover this charge. We ask that you arrive promptly so you will have sufficient time for your appointment. Initial_____

Financial ---We participate with most major insurance companies. As a courtesy to you, we will bill your insurance. It is your responsibility to verify your benefits and our participation with your insurance company, prior to your appointment. Patients are responsible for the full balance on their accounts. Deductibles, co-payments and co-insurance amounts are due in full at the time services are rendered. Prior authorization must be received prior to your appointment (s). It is your responsibility to verify authorization has been received. Self pay or no insurance ---Payment is due in full at the time services are rendered, unless special arrangements have been approved by our business office. Initial_____

Please feel free to call us if you have any questions or concerns.

Sincerely,

Rocky Mountain Health and Wellness Staff

Date: _____

GENERAL INFORMATION

Name: _____

First Middle Last

Home Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Gender: ☐ Female ☐ Male ☐ Married ☐ Single ☐ Divorced ☐ Other _____

Race: ☐ African-American ☐ Native American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

Employer: _____

Occupation: _____

Email: _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Religious Preference: _____

Referred by: ☐ Radio ☐ Website ☐Media ☐ Friend or Family Member ☐ Other _____

INSURANCE INFORMATION

Primary Insurance

Primary Ins. Name: _____

Group Number: _____

ID Number: _____

Guarantor's Name: _____

Date of Birth: _____

Secondary Insurance

Secondary Ins. Name: _____

Group Number: _____

ID Number: _____

Guarantor's Name: _____

Date of Birth: _____

PHARMACY INFORMATION

Primary Pharmacy Name _____

Cross Streets _____

Phone Number _____

Compounding Pharmacy Name _____

Phone Number _____

Mail Order Pharmacy Name _____

Phone Number _____

Patient Name:_____

Health Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these written questions. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. **Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.**

Complaints/ Concerns

What do you hope to achieve in your visit with us?

_____

If you had a magic wand and could erase three problems, what would they be?

1._____

2. _____

3. _____

When was the last time you felt well?

_____

_____

Did something trigger your change in health?

_____

_____

What makes you feel worse?

_____

_____

What makes you feel better?

_____

_____

When was your last exam? (If applicable)

Last Physical Exam: _____

Last Lab Work: _____

Last Dental: _____

Last Eye Exam: _____

Last Pap Smear:_____

Last Mammogram: _____

Last Bone Density: _____

Last Cardiac Stress Test: _____

Last EKG: _____

Last Hemoccult Test: _____

Last PSA (men only): _____

Last Rectal Exam (male only): _____

Upper Endoscopy: _____

Last Colonoscopy: _____

Have you had any recent imaging done? (MRI, CT Scan, Ultrasound) : _____

MEDICATIONS

Current Medications

Medication	Dose	Frequency	Start Date	Reason for use

Previous Medications (last 10 years)

Medication	Dose	Frequency	Start Date	Reason for use

Nutritional Supplements (Vitamins/mineral/herbs/homeopathy)

Supplement and Brand	Dose	Frequency	Start Date	Reason for use

Please list current problems in order of priority, and fill in the other boxes as completely as possible. Thank you.

MEDICAL HISTORY

1st Box = Past Condition 2nd Box = Ongoing Condition
Check appropriate box and provide date of onset

Gastrointestinal
☐ ☐ Irritable Bowel Syndrome _____
☐ ☐ Inflammatory Bowel Disease _____
☐ ☐ Crohn's _____
☐ ☐ Ulcerative Colitis _____
☐ ☐ Gastritis or Peptic Ulcer Disease _____
☐ ☐ GERD (Reflux) _____
☐ ☐ Celiac Disease _____
☐ ☐ Other _____

Cardiovascular
☐ ☐ Heart Attack _____
☐ ☐ Other Heart Disease _____
☐ ☐ Stroke _____
☐ ☐ Elevated Cholesterol _____
☐ ☐ Arrhythmia _____
☐ ☐ Hypertension (High Blood Pressure) _____
☐ ☐ Rheumatic Fever _____
☐ ☐ Mitral Valve Prolapse _____
☐ ☐ Other _____

Metabolic/ Endocrine
☐ ☐ Type 1 Diabetes _____
☐ ☐ Type 2 Diabetes _____
☐ ☐ Hypoglycemia _____
☐ ☐ Metabolic Syndrome _____
(Insulin Resistance or Pre Diabetes)
☐ ☐ Hypothyroidism (low thyroid) _____
☐ ☐ Hyperthyroidism (overactive Thyroid) _____
☐ ☐ Endocrine Problems _____
☐ ☐ Polycystic Ovarian Syndrome (PCOS) _____
☐ ☐ Infertility _____
☐ ☐ Weight Gain _____
☐ ☐ Weight Loss _____
☐ ☐ Frequent Weight Fluctuations _____
☐ ☐ Bulimia _____
☐ ☐ Anorexia _____
☐ ☐ Binge Eating Disorder _____
☐ ☐ Night Eating Disorder _____
☐ ☐ Eating Disorder (non specific) _____
☐ ☐ Other _____

Cancer
☐ ☐ Lung Cancer _____
☐ ☐ Breast Cancer _____
☐ ☐ Colon Cancer _____
☐ ☐ Ovarian Cancer _____
☐ ☐ Prostate Cancer _____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

Genital and Urinary Systems
☐ ☐ Kidney Stones _____
☐ ☐ Gout _____
☐ ☐ Interstitial Cystitis _____
☐ ☐ Frequent Urinary Tract Infections _____
☐ ☐ Frequent Yeast Infections _____
☐ ☐ Erectile Dysfunction _____
☐ ☐ Sexual Dysfunction _____
☐ ☐ Other _____

Musculoskeletal/Pain
☐ ☐ Osteoarthritis _____
☐ ☐ Fibromyalgia _____
☐ ☐ Chronic Pain _____
☐ ☐ Other _____

Inflammatory/Autoimmune
☐ ☐ Chronic Fatigue Syndrome _____
☐ ☐ Autoimmune Disease _____
☐ ☐ Rheumatoid Arthritis _____
☐ ☐ Lupus SLE _____
☐ ☐ Immune Deficiency Disease _____
☐ ☐ Herpes-Genital _____
☐ ☐ Severe Infectious Disease _____
☐ ☐ Poor Immune Function _____
(Frequent Infections)
☐ ☐ Food Allergies _____
☐ ☐ Multiple Chemical Sensitivities _____
☐ ☐ Latex Allergy _____
☐ ☐ Other _____

Respiratory Disease
☐ ☐ Asthma _____
☐ ☐ Chronic Sinusitis _____
☐ ☐ Bronchitis _____
☐ ☐ Emphysema _____
☐ ☐ Pneumonia _____
☐ ☐ Tuberculosis _____
☐ ☐ Sleep Apnea _____
☐ ☐ Other _____

Skin Diseases
☐ ☐ Eczema _____
☐ ☐ Psoriasis _____
☐ ☐ Acne _____
☐ ☐ Melanoma _____
☐ ☐ Skin Cancer _____
☐ ☐ Other _____

MEDICAL HISTORY *Continued*

Neurology/Mood

☐ ☐ Depression _____
☐ ☐ Anxiety _____
☐ ☐ Bipolar Disorder _____
☐ ☐ Schizophrenia _____
☐ ☐ Headaches _____
☐ ☐ Migraines _____
☐ ☐ ADD/ ADHD _____
☐ ☐ Autism _____
☐ ☐ Mild Cognitive Impairment _____
☐ ☐ Memory Problems _____
☐ ☐ Parkinson's disease _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ ALS _____
☐ ☐ Seizures _____
☐ ☐ Other Neurological Problems _____

ALLERGIES

Medication/Supplement/Food	Reaction *(Hives, Difficulty breathing, nausea)*
_____	_____
_____	_____
_____	_____
_____	_____

GYNECOLOGIC HISTORY **(for women only)**

Menstrual History

Age of first period: _____ Menses Frequency: _____ Length: _____

Do you experience pain with your menses? ☐ Yes ☐ No Clotting? ☐Yes ☐ No

Has your period ever skipped? ☐ Yes ☐ No For How long? _____

Last Menstrual period: _____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How Long? _____

Do you use contraception? ☐ Yes ☐ No If no, do you use: ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Do you experience or have you ever experienced any of the following: ☐ Fibrocystic Breasts ☐ Endometriosis

☐ Fibroids ☐ Painful Periods ☐ Heavy Periods ☐ PMS ☐ Infertility

Last Pap test: _____ ☐ Normal ☐ Abnormal

Have you ever been pregnant? ☐ Yes ☐ No

Last Mammogram: _____ ☐ Breast Biopsy/Date _____

Date of Last Bone Density _____ Results: ☐ High ☐ Low ☐ within Normal Range

Are you in menopause? ☐ Yes ☐ No

Age at Menopause _____

☐ Hot Flashes ☐Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido

☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of hormone replacement therapy? ☐ Yes ☐ No How Long? _____

Obstetric History
Check box if yes and provide number of

Number of times pregnant: _____ Number of Completed Pregnancies: _____

Pregnancy #1 ☐ Normal Vaginal Delivery ☐ Complications (please state): _____

Pregnancy #2 ☐ Normal Vaginal Delivery ☐ Complications (please state): _____

Pregnancy #3 ☐ Normal Vaginal Delivery ☐ Complications (please state): _____

(Complications include: Caesarean, Toxemia, Gestational Diabetes, Abortion, Miscarriage, still birth, ectopic pregnancy, and pre-term delivery)
Post Partum Depression: ☐ Yes ☐ No If yes, which pregnancy(s) _____

Breast Feeding ☐ Yes ☐ No If yes, which pregnancy(s): _____

Baby over 8 pounds ☐ Yes ☐ No If yes, which pregnancy: _____

MEN'S HISTORY (for men only)

Have you had a PSA done? ☐ Yes ☐ No

PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty maintaining an Erection

☐ Nocturia (urination at night). How many times at night? _____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

Surgical History ☐ None

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations ☐ None

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Blood Type: ☐ A ☐ B ☐ AB ☐ O ☐ RH +
☐ Unknown

FAMILY HISTORY

Check all family members that apply.	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Brother	Brother #2	Brother #3	Sister	Sister #2	Sister #3	Child #1	Child #2	Child #3	Aunt	Uncle	Other
Age (If Still Alive)																		
Age at death (if deceased)																		
Cancers																		
Colon Cancer																		
Breast or Ovarian Cancer																		
Heart Disease																		
Hypertension																		
Obesity																		
Diabetes																		
Stroke																		
Inflammatory Arthritis (Rehumatoid, Psoriatic, Ankylosing Spondylitis)																		
Inflammatory Bowel Disease																		
Multiple Sclerosis																		
Auto Immune Disease (Such as Lupus)																		
Irritable Bowel Syndrome																		
Celiac Disease																		
Asthma																		
Eczema/Psoriasis																		
Food Allergies, Sensitivities or Intolerances																		
Environemntal Sensitivities																		
Dementia																		
Parkinson's																		
ALS or Motor Neuron Diseases																		
Genetic Disorders																		
Substance Abuse (such as alcoholism)																		
Psychiatric Disorders																		
Depression																		
Schizophrenia																		
ADHD																		
Autism																		
Bipolar Disease																		
Thyroid Disease																		
Osteoporosis																		
Migraines																		
Anemia																		
Other																		

SOCIAL HISTORY

Nutrition/Diet
Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy ☐ No Wheat

☐ Gluten Restricted ☐ Vegetarian ☐ Vegan

☐ Specific Program for Weight Loss/ Maintenance Type: _____ ☐ Other _____

Do you have a history of an eating disorder? ☐ Yes ☐ No ☐ Bulimia ☐ Anorexia ☐ Compulsive Overeating

Dental History
Dental Surgery ☐ Yes ☐ No

☐ Silver Mercury Fillings How many? _____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with chewing

Do you floss regularly? ☐ Yes ☐ No

GI History
Foreign Travel? ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Have you ever had severe Gastroenteritis ☐ Diarrhea ☐

Do you feel like you digest your food well? ☐ Yes ☐ No

Do you feel bloated after meals? ☐ Yes ☐ No

Do you experience nausea or vomiting? ☐ Yes ☐ No

Safety
Did you feel safe growing up? ☐ Yes ☐ No

Have you been involved in abusive relationships in your life? ☐ Yes ☐ No

Do you currently feel safe in your current relationship? ☐ Yes ☐ No

Have you had any traumatic life experiences, or have you witnessed any violence or abuse? ☐ Yes ☐ No

Medication Use
Have your medications or supplements ever cause you unusual side effects or problems? ☐ Yes ☐ No

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Etc) Motrin, or Aspirin? ☐ Yes ☐ No

Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc) ☐ Yes ☐ No

Frequent Antibiotics > 3 times per year ☐ Yes ☐ No

Long Term Antibiotics? ☐ Yes ☐ No

Use of Steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes ☐ No

Use of oral contraceptives? ☐ Yes ☐ No

Sleep/Rest
Average number o hours you sleep per night: ☐ >10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No Explain: _____

Smoking
Currently Smoking? ☐ Yes ☐ No How many years? _____ Packs per day: _____

Attempts to quit: _____ Previous Smoking: How many years? _____ Packs per day? _____

2nd Hand smoke exposure? _____

Eating Habits
☐ Binge Eating ☐ Bulimia ☐ Can't Gain Weight ☐ Can't Lose Weight ☐ Can't Maintain Healthy Weight

☐ Frequent Dieting ☐ Poor Appetite ☐ Salt Cravings ☐ Carbohydrate Craving (breads, pastas)

☐ Sweet Cravings (candy, cookies, cakes) ☐ Chocolate Cravings ☐ Caffeine Dependent

Alcohol Intake
How many drinks currently per week? 1 drink= 5 oz wine, 12 oz beer, 1.5 oz spirits

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ > 10 ☐ None If none, skip to other substances

Previous alcohol intake? ☐ Yes (☐ Mild, ☐Moderate, ☐ High) ☐ None

Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No

Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No

Do you ever take an eye-opener? ☐ Yes ☐ No

Do you notice a tolerance to alcohol (can you handle more than others?) ☐ Yes ☐ No

Caffeine
Caffeine intake: ☐ Yes ☐ No Cups/Day: ☐ Coffee ☐ Tea ☐ 1 ☐ 2-4 ☐ >4 a day

Caffeinated sodas or diet sodas intake: ☐ Yes ☐ No

12-ounce can/bottle per day ☐ 1 ☐ 2-4 ☐ > 4 a day

List favorite type: Ex. Diet, Coke, Pepsi, Energy Drinks etc_____

Education
Highest level of education: ☐ High School ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Exercise Current Exercise program: Activity (List type, number of sessions/week and duration of activity)

Activity	Type	Frequency per week	Duration in minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotronics, etc)			
Sports or Leisure Activites (Golf, Tennis, rollerblading, etc)			

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No Type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐

Mood/Stress

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No

Currently?___ Previously: from_____ to _____

Comments: _____

Are there any areas of your life that you feel could be improved or that are sources of stress for you? ☐ job/school ☐ social life ☐ close friends ☐ partner/spouse ☐ children ☐family ☐ attitude/mood

Comments_____

How do you cope with stress?_____

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

Constitutional
☐ Unusual weight
☐ Recent weight change
☐ Fatigue
☐ Chills
☐ Fever

ENT
☐ Hearing Changes
☐ Tinnitus
☐ Vertigo
☐ Earache
☐ Infection
☐ Discharge
☐ Frequent colds
☐ Nasal Stuffiness
☐ Itching
☐ Nosebleeds
☐ Sinus Trouble
☐ Bleeding Gums
☐ Sore Throat
☐ Hoarseness
☐ Lumps in the neck

Cardiology
☐ Chest pain or Discomfort
☐ Palpitations
☐ Dyspnea
☐ Edema
☐ Heart Murmurs
☐ Edema or Dyspnea on Exertion

Respiratory
☐ Cough
☐ Sputum
☐ Hemoptysis
☐ Wheezing
☐ Asthma
☐ Bronchitis
☐ Pleurisy
☐ Shortness of breath,
☐ Wheezing

Gastrointestinal
☐ Trouble swallowing
☐ Heartburn
☐ Appetite changes
☐ Nausea
☐ Vomiting
☐ Regurgitation
☐ Vomiting of Blood
☐ Indigestion

Gastrointestinal Cont'd
☐ Change in bowel habits
☐ Rectal Bleeding
☐ Tarry stools
☐ Hemorrhoids
☐ Constipation
☐ Diarrhea
☐ Abdominal pain
☐ Food Intolerance
☐ Excessive belching or passing of gas
☐ Bloating

Female
☐ Breast lumps
☐ Pain or discomfort
☐ Nipple Discharge
☐ Vaginal Discharge
☐ Itching sores

☐ Heavy Menstrual Bleeding
☐ Painful menstrual cycles
☐ Irregular cycles
☐ Pain with intercourse

Male
☐ Hernias
☐ Penile discharge or sores
☐ Testicular pain or masses
☐ Difficulties obtaining or maintaining An erection
☐ Decreased Libido

Urinary
☐ Urinary frequency
☐ Nocturia
☐ Burning or pain on urination
☐ Hematuria
☐ Urgency
☐ Reduced force of the urinary stream
☐ Hesitancy
☐ Incontinence
☐ Urinary infections or stones

Musculoskeletal
☐ Muscle or join pains
☐ Stiffness
☐ Arthritis
☐ Gout
☐ Back Pain

Neurology
☐ Fainting
☐ Blackouts
☐ Seizures
☐ Weakness
☐ Paralysis
☐ Numbness
☐ Tingling
☐ Tremors or other involuntary movements

Psychology
☐ Nervousness
☐ Tension
☐ Anxiety
☐ Depression
☐ Mood Swings
☐ Irritability
☐ Suicidal Ideation
☐ Insomnia
☐ Memory changes

Endocrinology
☐ Thyroid Trouble
☐ Heat or Cold Intolerance
☐ Excessive sweating
☐ Diabetes
☐ Excessive thirst or hunger

Skin
☐ Rashes
☐ Lumps
☐ Sores
☐ Itching
☐ Dryness
☐ Color change
☐ Changes in hair or nails

Hematology
☐ Anemia
☐ Easy bruising or bleeding
☐ Past transfusions and Possible reactions

Patient HIPAA Consent Forms

Effective April 14, 2003 our office implemented the requirements of the Health Insurance Portability and Accountability Act (HIPAA), which was passed by the federal legislature.
I understand that Rocky Mountain Health & Wellness and/or its practitioners may need to use and disclose information about my health or medical problems for the purposes of arranging, conducting, or referring my treatment; for obtaining payment of services, and for operating the practice. I consent to the use of my information for the purposes of treatment, payment, and health care operations.
I understand that my consent is not needed if the law requires Rocky Mountain Health & Wellness and/or its practitioners to report some aspect of my protected health information to a government agency (for example, suspected abuse, communicable disease, and potential for serious bodily harm to myself or others).
I understand that I have the right to review the privacy notice posted at Rocky Mountain Health & Wellness to request restrictions on the use of my information and to revoke my consent at a later date.
Please review the "Privacy Notice" and indicated that you have reviewed this document by signing below.

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider Notice of Privacy Practice.

_____

Signature of Patient or Guardian Printed Name Date

Office Policy Consent Form

***PLEASE READ THE UPDATED OFFICE POLICY INFORMATION AND INITIAL AFTER EACH SECTION. IF YOU HAVE ANY QUESTIONS, COMMENTS, OR CONCERNS PLEASE ASK TO SPEAK WITH OUR OFFICE MANAGER. ***

Consent to Treat
I consent to, and authorize the health care practitioners of Rocky Mountain Health & Wellness to furnish me with necessary medical care. This medical care may include radiology examinations, laboratory testing and other diagnostic procedures as may be required**.**
Initials _____

Release of Medical Information
I consent to, and authorize the Rocky Mountain Health & Wellness practitioners to disclose all or part of my medical record to any mutually agreed upon referral provider. **Initials _____**

Insurance Authorization and Assignment of Benefits
I consent to, and authorize Rocky Mountain Health & Wellness to furnish medical information to any third party who may be responsible for payment of all or part of my charges incurred at Rocky Mountain Health & Wellness. I authorize my insurance company, or any responsible third party to pay benefits directly to Rocky Mountain Health & Wellness. **Initials _____**

Financial Responsibility
I understand that I am financially responsible for the payment of medical charges incurred on my behalf at Rocky Mountain Health & Wellness, regardless of third party coverage. I will pay any legal fees incurred by Rocky Mountain Health & Wellness in collecting on this account.
Initials _____

Appointments
If you are more than 15 minutes late for your scheduled appointment you may be asked to reschedule your appointment. **Initials _____**

Cancellation Policy
Please try to be on time to your appointment and give the office at least 24 hours notice if you need to cancel or change your appointment time. If you are unable to keep your appointment, please let the office know as soon as possible. With the exception of emergencies and other unusual circumstances, you will be billed $75.00 for appointment no-shows and cancellations made less than 24 hours in advance.
Initials _____

Payments
You are expected to pay your insurance co-payment at the time of visit. For self-pay patients, full payment is expected at the time of service. We accept cash, credit cards, checks, and money orders. There is a $25 charge on all returned checks or insufficient funds. We don't accept post dated checks. **Initials _____**

Insurance & Credit Policy
It is our desire to provide quality health care services to all individuals with or without healthcare insurance. Payment is due in full at the time services are rendered, unless special arrangements have been approved by our Business Office. For those individuals with insurance, we expect you to be aware of your policy and what it covers. Please find out from your insurance carrier if you have wellness benefits and be sure to let us know at the time of your visit so we can bill appropriately. Your insurance coverage and policy is a contract between you and your insurance company. If you have not met your deductible you will be expected to pay your visit in full. While the filing of insurance claims is a courtesy, which this office extends to all patients, all charges are your responsibility and must be paid within 30 days form the time services are rendered. If you are unable to pay your bill within that time frame you are responsible for making payment arrangements with

the billing office to avoid collections. Fees for services depend on the length of your visit and the complexity of your healthcare needs. If you have any concerns about a bill, please feel free to contact our billing office. **Initials _____**

Medications/Prescriptions
Patients requiring medications are provided with a prescription at the time of the office visit. Patients requiring refills on their prescriptions outside of an office visit must contact their pharmacy and the pharmacy must request a refill from this office. We request that you allow at least 24 hour turn around for this service. You the patient are responsible for mailing written prescriptions to your mail order pharmacies. We strictly adhere to rules governing the follow-up of patients on medications for your protection. The state of Idaho requires a medical check up prior to re-issuance of a prescription at a minimum of every six months. Certain medications may require lab test and more frequent medical check ups. **Initials _____**

Wellness Exams
Wellness exams may be covered by your insurance company on an annual basis. Some insurance companies cover these exams at 100% while others may charge your routine co-pay. If you are unsure what your insurance company allows please call them ahead of time to find out. Wellness exams are specifically designed to address; Prevention, education and counseling, anticipatory guidance, risk factor reduction and may involve ordering labs/procedures. If you are experiencing a health problem or have an acute illness you should consider rescheduling your wellness exam. If the practitioner addresses a health care problem or illness during your wellness exam you will be responsible for an additional co-pay or office visit charge. This does not apply to patients with stable chronic health conditions. Please let the receptionist know when you call in to schedule your appointment to ensure adequate time to set aside for your visit. There is usually not enough time during a wellness visit to address new acute problems, or new chronic symptoms.
Initials _____

Routine Office Visits
A routine office visit is approximately 15-20 minutes. If you have more than one medical problem to discuss with the health care provider please inform the receptionist at the time of scheduling your appointment as this may require an extended visit. **Initials _____**

I have read and understand all of the above information.

_____

Signature of Patient or Guardian **Printed Name** **Date**

Thank you for choosing us as your health care provider. We appreciate your trust in us, and we appreciate the opportunity to serve you.

Consent for Phone Contact Form

If we attempt to contact you and do not reach you in person, please indicate which method(s) of leaving messages are acceptable to you:

It is OK to leave a voicemail message for me on my

☐ Home Phone _____

☐ Cell Phone _____

☐ Work Phone _____

☐ Other (specify)_____

It is OK to discuss medical information regarding me with:

☐ My husband/wife/partner _____ (print name)

☐ My power of attorney _____ (print name, relationship)

☐ Other _____ (print name, relationship)

☐ Never leave any medical information on any message for me, simply ask me to call back.

☐ It is OK to email me with medical information at _____

_____
Print Name

_____
Signature Date