



**MOUNTAIN
PODIATRY**

WELCOME TO MOUNTAIN PODIATRY, LTD.

PATIENT REGISTRATION FORM

PLEASE HAVE YOUR INSURANCE AND IDENTIFICATION CARDS AVAILABLE

TODAY'S DATE: _____ PATIENT'S NAME: _____
 AGE: _____ DATE OF BIRTH: ____/____/____ GENDER: MALE FEMALE
 ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____
 TELEPHONE #'S: HOME: _____ CELL: _____ WORK: _____
 E-MAIL ADDRESS: _____ LANGUAGE SPOKEN: _____
 RACE: CAUCASIAN ASIAN AFRICAN AMERICAN HISPANIC OTHER: _____
 SPOUSE/PARENT NAME: _____
 TELEPHONE #'S: HOME: _____ CELL: _____ WORK: _____

FAMILY PHYSICIAN: _____ TELEPHONE #: _____
 EMERGENCY CONTACT: _____ TELEPHONE #: _____

HEALTH INSURANCE & PHARMACY INFORMATION:

PRIMARY INS. COMPANY: _____ TELEPHONE #: _____
 INSURED'S NAME: _____ D.O.B.: ____/____/____ GENDER: MALE FEMALE
 MEMBER ID#: _____ PLAN/GROUP#: _____
 SECONDARY INS. COMPANY: _____ TELEPHONE #: _____
 INSURED'S NAME: _____ D.O.B.: ____/____/____ GENDER: MALE FEMALE
 MEMBER ID#: _____ PLAN/GROUP#: _____

PHARMACY: _____
 ADDRESS: _____ CITY: _____ STATE: _____

SIGNATURE CONSENT TO CHECK ERX MEDICATION HISTORY: _____

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Mountain Podiatry, Ltd., and associated medical providers. I authorize Mountain Podiatry to release any information acquired in the course of my treatment needed for all medical insurance claims. A photocopy of this authorization is to be considered as valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or third party payor is involved with payment. I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services and yearly deductibles. I agree to pay all collection expenses including a \$35.00 returned check fee, attorney's fees, court costs, filing fees, including charges that may be assessed by any collection agency retained to pursue this matter. Payment for these services is expected at the time services are rendered. If Mountain Podiatry, Ltd. doctors and associated medical providers are Preferred Providers of your insurance company, we are required by your insurance company to collect your financial portion at the time services are rendered. You will also be responsible to pay a 24 hours No Show/Cancellation Fee of \$50.00 for an office visit and \$100.00 fee for any scheduled surgical procedure.

Patient/Parent/Guardian Signature

Date



ACKNOWLEDGEMENT OF
RECEIPT OF
NOTICE OF
PRIVACY PRACTICES

I acknowledge that I have been provided the Mountain Podiatry, Ltd's Notice of Privacy Practices:

- It tells me how Mountain Podiatry, Ltd. will use my health information for the purpose of my treatment, payment for my treatment, and Mountain Podiatry, Ltd's health care operations.
- The Notice of Privacy Practices explains in more detail how Mountain Podiatry, Ltd. may use and share my health information for other than treatment, payment, and health care operations.
- Mountain Podiatry, Ltd. will also use and share my health information as required/permitted by law.

Mountain Podiatry, Ltd. may release or disclose my Protected Health Information to the following:

_____ relationship to patient: _____
_____ relationship to patient: _____
_____ relationship to patient: _____
_____ relationship to patient: _____

Patient's Complete Legal Name: _____
(Please Print Name)

Patient's Date of Birth: _____

Signature of Patient or Legal Representative: _____
(Legal Representative may be requested to show proof of representative status)

PLEASE NOTE IT IS YOUR RIGHT TO REFUSE TO SIGN THE ACKNOWLEDGEMENT

FOR ADMINISTRATOR ONLY:

Mountain Podiatry, Ltd. tried to obtain written acknowledgement by the individual noted above of the receipt of "Notice of Privacy Practices", but it could not be obtained for the following reason:

- ___ An emergency prevented us from obtaining acknowledgement
- ___ A communication barrier prevented us from obtaining acknowledgement
- ___ Patient was unwilling to sign

Staff Members Signature

Date



**MOUNTAIN
PODIATRY**

INJURY ACCIDENT REPORT FORM
REQUIRED BY ALL INSURANCE COMPANIES

TODAY'S DATE: _____

PATIENT'S NAME: _____

IS THIS DUE TO AN INJURY? YES NO (IF NO, MOVE TO THE BOTTOM OF PAGE, SIGN & DATE)

DATE OF INJURY? ____/____/____

HAVE YOU NOTIFIED YOUR EMPLOYER? YES NO

EMPLOYER AT THE TIME OF INJURY? _____

ARE YOU CURRENTLY WORKING? YES NO

DESCRIBE WHAT PART OF THE BODY WAS INJURED: _____

DESCRIBE WHERE AND HOW THE INJURY OCCURRED: _____

WAS A POLICE REPORT FILED? YES NO

WHO CAUSED OR MAY HAVE CAUSED THIS ACCIDENT?

NAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

INSURANCE INFORMATION:

HAVE YOU NOTIFIED YOUR INSURANCE COMPANY? YES NO

AUTO INSURANCE COMPANY: _____ PHONE#: _____

AUTO INS. ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

POLICY# _____ CLAIM#: _____

INSURANCE ADJUSTER'S NAME: _____ PHONE #: _____

ATTORNEY INFORMATION:

DO YOU HAVE AN ATTORNEY? YES NO

ATTORNEY'S NAME: _____ PHONE#: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

I HEREBY VERIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT/PARENT/GUARDIAN'S SIGNATURE

DATE



MOUNTAIN PODIATRY

INFORMATION ON PATIENT HEALTH CARE RECORDS

NRS 629.061: (Section 1)

Each custodian of health care records shall make the health care records of a patient available for physical inspection by:

- (a) The patient or a representative with written authorization from the patient;
- (b) The personal representative of the estate of a deceased patient;
- (c) Any trustee of a living trust created by a deceased patient;
- (d) The parent or guardian of a deceased patient who died before reaching the age of majority;
- (e) An investigator for the Attorney General or a grand jury investigating an alleged violation of NRS 200.495, 200.5091 to 200.50995, inclusive, or 422.540 to 422.570, inclusive;
- (f) An investigator for the Attorney General investigating an alleged violation of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive, or any fraud in the administration of chapter 616A, 616B, 616C, 616D or 617 of NRS or in the provision of benefits for industrial insurance;
- (g) Any authorized representative or investigator of a state licensing board during the course of any investigation authorized by law; **or**
- (h) Any coroner or medical examiner to identify a deceased person, determine a cause of death or perform other duties as authorized by law.

PATIENTS HEALTH CARE RECORDS ARE KEPT FOR 5 YEARS AFTER THE LAST VISIT THAT THE PATIENT HAS WITH OUR DOCTOR OFFICE. AS LONG AS THE PATIENT CONTINUES TO BE SEEN RECORDS ARE MAINTAINED.

Patient Signature

Date

MP Representative

Date