First Point of Contact Screening

Patient Name_____ **Date**_____
Please print full legal name

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

   If yes, please circle the symptoms you have now, or have had, over the past seven days?
   - fever
   - night sweats
   - sneezing or runny nose
   - severe headache
   - stiff neck
   - muscle or joint pain (circle one or both)
   - new rashes or open sores on your skin or in your mouth
   - redness, swelling, or discharge of your eyes (pink eye)
   - unexplained bleeding
   - vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

   If yes, please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

   If yes, please list where: _____

Thank you for your help and support in caring for our patients and community.

*****TO BE FILLED OUT BY OFFICE STAFF*****

Reviewed by:_____

Action taken:
- ☐ No action taken
- ☐ Isolate
- ☐ Cough/ hand washing etiquette provided
- ☐ Mark provided
- ☐ PM/ Lead clinical provided

Thank you for trusting us with your healthcare!

Revised: 01/11/17

Health ONE Mountain Vista OB/GYN and Midwifery Physician Care℠

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witness	Employee Job Title
Signature of Witness	**Date**

Revised 1/11/17

Mountain Vista OB/GYN and Midwifery
Physician Care℠

Patient Responsibility Policy

Thank you for choosing Mountain Vista OB/GYN and Midwifery for your OB/GYN needs.
In order to achieve our goal in providing and maintaining a good physician-patient relationship we believe it is important to have solid policies in place. The policy below is designed to help provide our patients with high quality, cost-effective and timely health care. We ask that you carefully read and sign the following expectations prior to your visit.

A 24 hour notice is expected for all appointment cancellations and reschedules.

- If you ***fail*** to notify us of a cancellation or reschedule your appointment it will result in a "No-Show/ No-Call".

Patients with repeat "No-show/ No-Call's" are subject to review with possible discharge from the practice.

Patients are expected to arrive **15 min. prior to their scheduled appointment time** to accommodate the check-in process.

- If you **fail** to arrive 15 min. prior to your appointment you may be asked to reschedule.

Upon arrival, please sign in at the front desk and present complete insurance information.

- Which includes: current health insurance cards and proper picture ID.
- You will be asked to present both of these items at each visit for proper identification.
- If you ***fail*** to provide complete or current insurance information we may not be able to accurately file your claim(s) and you will be responsible for full payment until accurate information is submitted to our office.

Co-payments are expected to be paid at each visit if required by your insurance plan.

It is the patient's responsibility to know their healthcare benefits and coverage limitations.

- Any services determined NOT covered by your insurance plan will be the patient's responsibility to pay.

A 35 % discount is provided to patients without health care coverage or if we do not participate with their health plan.

I, the undersigned, have read and understand the Mountain Vista OB/GYN and Midwifery Patient Responsibility Policy above. I agree to comply and accept the terms and responsibility to the policy as outlined above. I agree to pay for all services rendered NOT covered by my insurance plan and to notify the office should there be any changes to my health insurance coverage.

_____
Patient Name (print)

_____ _____
Patient Signature (or Responsible Party) Date

Patient Privacy Policy

In an effort to protect your privacy, our practice standard does not allow sharing of medical information with anyone except the patient or legal guardian or for messages to be left on voice mail unless permission is given.
If you would like to grant permission please indicate below.

Approved phone numbers for detailed voice mail messages:

My home phone: _____ OTHER: _____
My cell phone: _____ *My Spouses phone:* _____
My work phone: _____ *My Spouses Name*: _____

I, the undersigned, give permission to the office of *Mountain Vista OB/GYN and Midwifery* to leave a phone message regarding my medical care on the numbers listed above, including the voice mail associated with that number.

_____ _____
Patient Signature (or Responsible Party) Date

Health ONE Mountain Vista OB/GYN and Midwifery Physician Care℠

Patient Review of Systems

Name: _____ Referring Provider: _____

DOB: _____ Other Physician/Specialist: _____

Occupation: _____ Marital Status: □ Married □ Single □ Divorced □ Widowed

Highest level of school completed: □ High school □College □ Graduate Degree □ other: _____

***Please answer all questions if applicable. All information will be kept confidential.**

Are you **currently** experiencing any of the following? (Please circle Yes or No)

Constitutional			**Resp./Pulmonology**			**Gynecology**			**Psychology**		
Fatigue	No	Yes	Coughing	No	Yes	Abnormal bleeding	No	Yes	Anxiety	No	Yes
Fever	No	Yes	Shortness of breath	No	Yes	Infertility issues	No	Yes	Changes in appetite	No	Yes
Weight loss	No	Yes	Sleep apnea	No	Yes	Painful intercourse	No	Yes	Depression	No	Yes
Weight gain	No	Yes	Wheezing	No	Yes	Pelvic pain	No	Yes	Insomnia	No	Yes
Skin & Breast			**Cardiology**			Vaginal discharge	No	Yes	**Hem/ Lymph**		
Breast discharge	No	Yes	Chest pain	No	Yes	Vaginal itching	No	Yes	Anemia	No	Yes
Lump in breast(s)	No	Yes	Swollen Ankles	No	Yes	**Musculoskeletal**			Bruising easily	No	Yes
Pain in breast(s)	No	Yes	Heart palpitations	No	Yes	Joint/back pain	No	Yes	Chills	No	Yes
Skin lesions	No	Yes	**Gastroenterology**			Muscle pain	No	Yes	Night Sweats	No	Yes
Dry skin	No	Yes	Abdominal pain	No	Yes	Muscle weakness	No	Yes	**Endocrinology**		
HEENT			Blood in stool	No	Yes	**Neurology**			Hair loss	No	Yes
Change in vision	No	Yes	Constipation/	No	Yes	Balance Issues	No	Yes	Hot flashes	No	Yes
Hearing Loss	No	Yes	Diarrhea	No	Yes	Numbness	No	Yes	Heat/Cold Intolerance	No	Yes
Ringing in ears	No	Yes	Nausea/Vomiting	No	Yes	Seizures	No	Yes			
Congestion	No	Yes	**Genital/Urinary**			Fainting	No	Yes			
Sore Throat	No	Yes	Blood in urine	No	Yes	Changes in speech	No	Yes			
Headache	No	Yes	Painful urination	No	Yes	Tingling	No	Yes			
			Frequent urination	No	Yes						
			Frequent UTI's	No	Yes						

Last Menstrual Period:_____

Medications and Vitamins:

Name	Dose

Allergies to Medications?

Review with patient. Provider Signature_____

Health ONE Mountain Vista OB/GYN and Midwifery Physician Care℠

Mountain Vista OB/GYN and Midwifery

Our practice is now on EMR and would like to web-enable you to our patient portal. You would be able to obtain your records online, see your lab/test results and send/receive secure messages to/from your provider. Do you consent to be web-enabled? YES _____ NO_____
***E-Mail Address:** _____

PATIENT INFORMATION (Please Print)

Patient's Name (Last) _____ (First) _____ (MI) _____ Previous Name: _____
DOB: _____ Sex: ☐ F – Female ☐ M – Male ☐ Transgender
Address: _____ Apt: _____
City: _____ State: _____ ZIP: _____
Home Phone: _____ Cell No. _____ SSN: _____
***E-Mail Address:** _____
Employer Name: _____ Work Phone: _____
Employment Status: ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 – Retired ☐ 6 - Active Military
Student Status: ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated Partner
Race: ☐ American Indian or Alaska Native ☐ Asian Native ☐ Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined
Language: ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Primary Care Physician (PCP): _____ Phone: _____
Pharmacy: _____ **Pharmacy Phone:** _____
Emergency Contact: Last Name: _____ First Name: _____
Phone Number: _____ Relationship to Patient: _____

RESPONSIBLE PARTY INFORMATION – ONLY IF PATIENT IS A MINOR (Or Power of Attorney relationship)
Check here if information is same as patient ☐ Responsible Party (**If minor**): ☐ Another Patient ☐ Guarantor
Responsible Party Name (Last) _____ (First) _____ (MI) _____
DOB: _____ Home Phone: _____ Cell No: _____
Address: _____ Apt: _____
City: _____ State: _____ ZIP: _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)
Insurance Company: _____ Phone: _____
Subscriber ID (Policy Number): _____ Group ID: _____
Name of Policy Holder: _____ Patient Relationship to Policy holder: _____
Policy Holder's DOB: _____ Effective Date: _____ Policy Holder's SS#:_____

SECONDARY INSURANCE INFORMATION (If Medicare, please provide reason) (provide your insurance card to the front desk at check-in)
Insurance Company: _____ Phone: _____
Subscriber ID (Policy Number): _____ Group ID: _____
Name of Policy Holder: _____ Patient Relationship to Policy holder: _____
Policy Holder's DOB: _____ Effective Date: _____ Policy Holder's SS#:_____
Medicare Secondary reason: ☐ Working Aged Beneficiary/Spouse ☐ Disabled Beneficiary under age ☐ Other liability

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature: _____ ***Date:*** _____

Revised 1/11/17