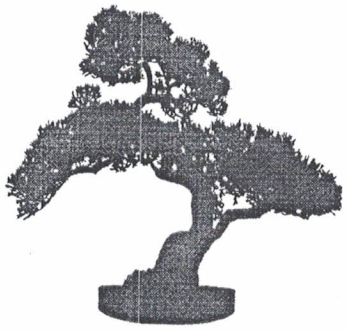

BLUE MOUNTAIN MEDICINE

150 South Caldwell Street
Brevard, NC 28712
(828) 883-4040 Fax: (828) 883-4060

Date_____

Patient's Name_____
Last First Middle

M___ **F**___ **Age**_____ **Date of Birth**_____

Patient's Social Security Number_____ **Email**_____

Parent or Guardian Name (if patient is under 18)_____

Mailing Address_____
Street City State Zip Code

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

In case of Emergency (Name)_____ **Phone**_____

Relationship to Patient_____

Patient's Employer_____ **Occupation**_____

Employer's Address_____
Street City State Zip Code

Preferred Pharmacy:_____

Insurance Information: **Primary Insurance Company Name:**_____

Secondary Insurance Company Name:_____

Patient (Parent or Guardian if under 18) Signature_____

BLUE MOUNTAIN MEDICINE

150 S. Caldwell St., Brevard, NC 28712
Phone (828) 883-4040 Fax (828) 883-4060

MEDICAL BILLING POLICIES AND PROCEDURES

It is the patients responsibility to be familiar with your insurance policy. To know what medical benefits are covered. Be familiar with deductibles, co-payments and percentages covered. Insurance coverage does not guarantee payment of services, all policies are based on eligibility. All claims are subject to review.

While BLUE MOUNTAIN MEDICINE is pleased to submit your claims to your insurance company on your behalf, payments for services are your responsibility. If the insurance reimbursement does not cover the charges, or coverage is denied, the remaining amount is your responsibility. YOU THE PATIENT ARE RESPONSIBLE FOR ALL CHARGES THAT HAVE BEEN INCURRED FOR SERVICES RENDERED.

NURSE VISITS:

To better serve our patients' needs, an occasion may arise in which it is appropriate for our nurse to handle the visits. The "Nurse Visits will often be planned ahead by Dr. Fisher as a re-evaluation or follow-up. Dr. Fisher will be in the building and all information from visit is reviewed by Dr. Fisher. His orders and instructions are part of this service.

The co-pay for these visits will be **waived**, but insurance will be filed for visit. If insurance denies charges patient will be charged $20.00 on next statement.

I authorize the release of any medical or other information concerning my present illness or injury that is necessary to process this claim.

I authorize payment of medical benefits to BLUE MOUNTAIN MEDICINE. I understand that I am responsible for the payment of these medical services in the event of non-payment by any third payer.

Signature_____Date_____

RIGHTS OF THE PATIENT: I understand that I have the right to revoke this authorization at any tine and that I have a right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to BLUE MOUNTAIN MEDICINE. I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. This authorization shall be in effect until revoked by the patient.

ACKNOWLEDGMENT OF RECEIPT OR NOTICE OF PRIVACY PRACTICES:

I,_____have been made available a copy of Blue Mountain Medicine's Notice of Privacy Practices.

Signature of Patient_____Date_____

Revised 10/02/2015 pr

BLUE MOUNTAIN MEDICINE
150 South Caldwell Street
Brevard, NC 28712
(828) 883-4040 Fax: (828) 883-4060

COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION/ ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

Patient's Name:_____ DOB:_____

Blue Mountain Medicine is authorized to release protected health information about the above-named patient to the entities named below. The purpose of this "Release of Information" is to allow the patient to choose to whom and what information we at Blue Mountain Medicine are allowed to release on their behalf.
***Please check a box [ ] next to what applies to you.

[ ] ***Messages***

Please call: [ ] My Home [ ] My Work [ ] My Cell Number_____

If you are unable to reach me:

[ ] You may leave a detailed message.

[ ] Please leave a message asking to return your call.

[ ] Other:_____

The best time to reach me is (day)_____between (time)_____.

[ ] ***Release of Information***

[ ] Spouse:_____ Phone #: _____

[ ] Children:_____ Phone #: _____

[ ] Other:_____ Phone #: _____

[ ] You may **share** my health information with other medical professionals to whom you may be consulting or referring me for treatment. (For example: a surgeon or dermatologist.)

[ ] I consent to and authorize _____ to **release** to **Blue Mountain Medicine** copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are part of my medical records.

[ ] (Patients under 18) I understand that you may leave appointments, results of labs and/or x-rays with my legal guardian. **Name of legal guardian:**_____

Signature_____ **Date**_____
*****This document expires 1 year from date.*****

BLUE MOUNTIN MEDICINE

NURSE VISITS

For Patient Information:

Explanation: To better serve our patients' needs, an occasion may arise in which it is appropriate for our nurse to handle the visits. The "Nurse Visits" will often be planned ahead by Dr. Fisher as a re-evaluation or follow-up.

Examples: Blood pressure management
Diabetic weight management or glucose management
Follow-up urinalysis for UTI

All Nurse Visits are done with Dr. Fisher in the building and all information from visit is reviewed by Dr. Fisher. His orders and instructions are part of this service.

Charges for Nurse Visits:

Insured – Co-pay will be waived, but insurance will be charged for visit.
If insurance denies charges patient will be charged $20.00 on next statement.

Uninsured – Visit charge for Nurse Visit is $20.00. Any other applicable service charges (lab tests or medications administered, etc.) will be an additional charge.

A physician visit will always be done if it is considered necessary by Dr. Fisher or if requested by patient and time allows. This visit will than be considered an office visit and all co-pays fees and all fees for uninsured, are payable at time of visit.

7/21/2015

BLUE MOUNTAIN MEDICINE
INITIAL MEDICAL HISTORY

NAME_____DATE OF BIRTH_____

I. ALLERGIES:Are you allergic to any medications or other substances that you know of. Or have you had any adverse reactions to anything you have been exposed to?

Medication/Substance	Reaction	Type of Reaction
Penicillin	Yes/No	_____
Sulfa Drug	Yes/No	_____
Morphine	Yes/No	_____
Demerol	Yes/No	_____
Latex	Yes/No	_____
IV Contrast Dye	Yes/No	_____
Eggs/Shellfish	Yes/No	_____
Other_____	Yes/No	_____

II. MEDICATIONS: What medications do you take routinely? Please include the strength, amount and frequency. (if you have a medication list, we can make a copy).

III. . SOCIAL HISTORY:

- Are you on short term or long term disability?_____
- Do you currently smoke? Yes/No How much_____How long_____
- Did you smoke in the past? Yes/No How much_____How long_____
- Do you use other forms of tobacco? Yes/No How much_____How long_____
- Is there second-hand smoke in your home? Yes/No
- Do you use alcohol currently or in the past? Yes/No If yes, how much/long:_____
- Do you have anyone living in the home with you? Yes/No
- Do you consider yourself to be at risk for falling? Yes/No
- Have you had a mammogram in the past 24 months? Yes/No
- Have you had a pneumonia vaccine? Yes/No
- Have you had a flu vaccine in the past 12 months? Yes/No

BLUE MOUNTAIN MEDICINE
Initial Medical History

Name_____ Date of Birth_____

IV. Past Medical History: Do you currently have any of the following health issues (or have you in the past)?

High Blood Pressure	Yes/No	High Cholesterol	Yes/No
Heart Disease	Yes/No	Stroke	Yes/No
Thyroid Disease	Yes/No	Arthritis	Yes/No
Depression	Yes/No	HIV	Yes/No
Pneumonia	Yes/No	Suicide Attempts	Yes/No
Obesity	Yes/No	Hemorrhoids	Yes/No

Diabetes Yes/No Type I/ Type II

Obstructive Sleep Apnea Yes/No Do you use CPAP? Yes/No

Hernia Yes/No Location:_____

Illnesses/ Injuries Yes/No _____

Hospitalizations Yes/No _____
(That were not for surgery)

Other: _____

V. Surgical History: Have you had any surgeries?

Heart Surgery	Yes/No	(Females)	Hysterectomy or Tubal Ligation	Yes/No
Hernia Repair	Yes/No	(Males)	Vasectomy	Yes/No
Gall Bladder Removal	Yes/No		Back Surgery	Yes/No
Appendectomy	Yes/No		Other:_____	

VI. Family History: Mark "Yes" for any illnesses that have affected blood relatives. List what relation the relatives are/were.
(Example: Cancer (Yes)/No- maternal grandmother (breast cancer).

Alcoholism Yes/No _____

Cancer Yes/No _____

Diabetes Yes/No _____

Heart Disease Yes/No _____
(Example: Heart attack, heart stent, bypass surgery, artificial valves or valve disorders, arrhythmia, etc.)

High Cholesterol Yes/No _____

High Blood Pressure Yes/No _____

Stroke/ TIA's Yes/No _____

Psychiatric Conditions Yes/No _____
(Diagnosed Conditions)