CopperView Medical Center

Adult Patient Registration

Date_____

Home Phone ( )_____ Cell Phone ( )_____ Work/Other ( )_____

Email Address _____

Preferred Method of contact for REMINDER CALLS (please ONLY check one of the following):

_____ Email, _____ Cell phone (TEXT), _____ Cell phone (CALL), _____ Home phone (call)

Name_____

Last First Middle

Address_____

City_____ State_____ Zip_____

Gender_____M _____F Birth Date_____/_____/_____ Marital Status_____

Month Day Year

SS#_____-_____-_____ How did you hear about us?? _____

Race:_____ Ethnicity:_____ ☐ efused

Primary Insurance Information

Policy Holder_____

Last First Middle

Relation to patient_____ Birth Date_____/_____/_____ SS#_____-_____-_____

Month Day Year

COPAY: $_____

Employer_____ Employer Phone # ( )_____

Insurance Company_____ Insurance Phone # ( )_____

Insurance Billing Address_____

Group#_____ ID/Subscriber#_____

Secondary Insurance Information

Policy Holder_____

Last First Middle

Relation to patient_____ Birth Date_____/_____/_____ SS#_____-_____-_____

Month Day Year

Employer_____ Employer Phone # ( )_____

Insurance Company_____ Insurance Phone # ( )_____

Insurance Billing Address_____

Group#_____ ID/Subscriber#_____

***Emergency Contact/Relation_____ Phone( )_____**

I the undersigned certify that I (or my dependent) have insurance coverage with the above listed insurance company and assign all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. If it becomes necessary to refer this account to a collection agency, I agree to pay a collection fee of 40% of the principal balance owing. I agree to pay $25.00 for any missed appointments and appointments canceled with less than a one hour notice of the appointment time. Further I agree to pay for any and all attorney fees and court cost incurred, should litigation become necessary.

_____ _____

Responsible Party Signature Date

_____

Relationship

Patient Name: _____ DOB: _____ Acct #: _____

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize CopperView Medical Center to use and/or disclose demographic, insurance and/or billing information (including diagnosis and procedure codes and descriptions) medical records, clinical notes, lab results, imaging results, referral information, etc about me to or for the party or parties listed below.

This authorization permits CopperView Medical Center to use or disclose to the following list of people(s).....

_____	___/___/___	_____	___/___/___
Name	Date of Birth	Name	Date of Birth
_____		_____	
Relationship		Relationship	

This authorization will expire on _____ (Expiration Date or Defined Event)
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that CopperView Medical Center has acted in reliance upon this authorization. My written revocation must be submitted to CopperView Medical Center's Privacy Officer.

Signed by: _____ _____
(Signature of Patient or Legal Guardian) (Date)

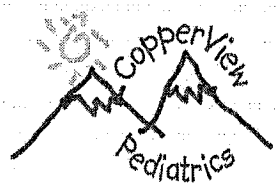
_____
Print Name of Patient or Legal Gaurdian

Prescription Release

I authorize CopperView Medical Center to release any and all prescription(s) written to myself or my dependent to the following individual(s). Prescriptions may be written under any provider practicing at CopperView Medical Center; including but not limited to controlled substances.

Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Phone #: _____	Phone #: _____

CopperView Medical Center



FINANCIAL POLICY AND AGREEMENT

Thank you for choosing CopperView Medical Center as your healthcare provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement, which you must read and sign prior to any medical evaluation or treatment.

1. Each patient is responsible for his or her own bill.

2. Payment of all insurance co-payments and deductibles is required at the time of service. What your insurance does not cover and you are responsible to pay, is a contract between you and your insurance company.

3. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is not possible, you will need to make payment arrangements with our billing office. We accept; cash, Visa/MasterCard, American Express, and Discover/Novus.

4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.

6. You are responsible for any laboratory service performed at these facilities that are sent out to a third party laboratory for processing. All billing for laboratory services are generated through the lab itself; we do however provide your insurance information to the lab for billing purposes only.

7. If for any reason, should collection become necessary, the responsible party agrees to pay an additional 40% collection fee of any charges being sent to the collection agency, and all legal fees of collection with or without suit including attorney fees and court fees.

8. Be aware that we may charge a $25.00 fee for no-showed appointments.

9. Be aware for any inadequate cancellation; defined as one hour or less of your appointment time, may be charged a $25.00 fee.

Usual and Customary Rates

Our rates for medical services reflect the usual and customary rates in the community.

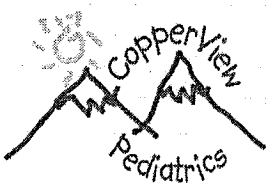
Authorization to Pay Benefits

I further authorize and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for payment to my provider when a statement is rendered.

_____ _____

Signature of patient or responsible party Date

CopperView Medical Center



Date: _____

I, _____, a patient, or legal guardian
(please print)

was made aware that there is a copy of the **CopperView Medical Center** Notice of HIPAA Privacy Practice, located in the waiting are. If I desire to obtain a copy of the Privacy Practice Pamphlet, one can be obtained from the front desk. I have been informed that should I have questions regarding this Privacy Policy or do not understand information in the Notice that I may direct these questions to the Privacy Officer.

_____ _____

Patient or Guardian Signature Date

FOR YOUR INFORMATION:

Dr. Hollingsworth, MD and Dr. Lei, MD are proud owners of Jordan Valley Medical Center, a physician-owned hospital under 42 U.S.C. §1395nn. At the time of a referral for any necessary hospital services, each of our patients may choose Jordan Valley Medical Center or any other facility, center or hospital for the purpose of having such services performed as determined by the patient to be in the patient's best interest.

For Office Use Only
Chart #: _____
Entered by MA: _____

Copperview Medical Center's New Patient History

Name: _____ Date of Birth: _____ Date: _____

Reason for today's visit (list your top one or two concerns)

1. _____
2. _____

Social History

Profession: _____ Currently Working: Yes / No / Retired
Marital Status: Never / Married / Divorced / Widowed Number of Children: _____
Do you have a history of alcohol use? No / Yes Do you currently consume alcohol? No / Yes
Approximately how many drinks weekly? <7 / 7-14 / 15-34 / 35-100+
Do you have a history of tobacco use? No / Yes Do you currently use tobacco? No / Yes
How many years total: _____ Smoking / Chewing Are you interested in quitting? No / Yes
Do you have a history of illicit drug use? No / Yes Do you currently use drugs? No / Yes
Do you exercise weekly? No / Yes How many hours weekly? <1 / 1-2 / 3-7 / 8-14+

Medical History (i.e., high blood pressure, high cholesterol, depression, operations, etc...)

Illnesses	Year of Diagnosis	Currently Being Treated?

Operations	Year of Operation	Reason for Operation

Do you have allergies to:

Medications? No / Yes

Medication: Reaction:

_____ _____
_____ _____
_____ _____

Food? No / Yes

Food: Reaction:

_____ _____
_____ _____

For Office Use Only
Chart #: _____

Current Medications

Medication	Dose	How many and how often are your pills taken daily?

Review of Symptoms

(Circle all you are currently experiencing or have had unusual or significant problems with)

General: Unexplained weight gain or loss / night sweats / fevers / chills / cold sweats
Mental: Depression / anxiety / confusion / slowed thinking
HEENT: Headaches / changes in hearing/vision / eye pain / congestion / sinus pain / sneezing / sore throat
Lung: Cough / short of breath (at rest / exertion) / wheezing / pain with breathing / coughing blood
Heart: Chest pain (at rest / exertion) / decreased exercise tolerance / sensation of racing heart
Stomach: Stomach pain / nausea / vomiting / diarrhea / constipation / bloody stools / black tarry stools
Muscle: Weakness / joint pains / swollen joints / broken bones
Nerve: Numbness / tingling in hands or feet / paralyzed limb / fainting / loss of balance
Urine: Burning with urination / frequent urination / waking at night to urinate / sexual dysfunction
Women: No periods / heavy periods / painful periods / irregular periods
Date of last period: _____ Menopause at age: _____

Family History (List the age of diagnosis)

Illness	Father	Mother	Brother	Sister	Child	Other
High Cholesterol						
High Blood Pressure						
Heart Attack						
Stroke						
Lung Problems						
Liver Problems						
Kidney Problems						
Diabetes						
Cancer: Lung						
Colon						
Prostate						
Breast						
Skin						
Liver						
Depression						
Anxiety						
Alzheimer's Disease						
Other Disease (List)						
Other Disease (List)						