DATE:_____

Patient Information

Thank you for choosing Blue Mountain Clinic! In order to serve you better, we need the following information. Please Print.

All information is confidential.

Name(First & Last)_____ Social Security # _____ Birthdate_____

Legal Name(if different)_____ What pronoun do you use?_____

*Strictly for insurance purposes.

Address_____APT_____City_____ County_____ST____ ZIP_____
E-mail_____Primary Phone_____

Gender_____
Special instructions for contacting you_____

For appointment reminders do you prefer_____Text_____Phone Call_____Both

Financially Responsible Party (if under 18)

Person responsible for this account_____Relationship to patient _____

Address_____City _____ST _____ZIP_____

Home Phone_____ Employer_____

Insurance Information

Primary Insurance Company_____Policy #_____

Group #_____Policy Holder Name_____

Social Security # of Policy Holder _____ Birthdate_____

Relationship to patient _____

Do you have additional insurance? Yes_____No_____ If yes, complete the following;

Secondary Insurance Company_____Policy #_____

Group#_____Policy Holder Name_____

Social Security # of Policy Holder_____ Birthdate_____

Relationship to patient_____

Over

Have you been a patient at Blue Mountain Clinic before? Yes ____ No_____

How did you find out about our clinic? _____

May we identify ourselves as Blue Mountain Clinic if we need to contact you? Yes ____ No_____

Release of Records for Insurance Billing

I understand that if I request Blue Mountain Clinic to file a claim with my insurance they may be required to release records to my insurance company. I authorize the release of these records to my insurance company. I also authorize payment to be made by my insurance company directly to Blue Mountain Clinic. I understand that some services at Blue Mountain Clinic require payment at time of service and insurance billing is not provided. A receipt for these services will be provided so I may file a claim with my insurance company.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____have received the Notice of Privacy Practices from Blue Mountain Clinic.

Signature_____ Date _____