High Mountain Healthcare, LLC
Fire Fighter Physical

ADULT PATIENT INFORMATION SHEET

Patient's Last Name_____ First_____ Middle Initial____

Mailing Address_____ City/State/Zip_____

Hm Phone(_____)_____ Wk Phone(_____)_____ Cell(___)_____

Birthdate_____ Soc. Sec. Nbr. _____ Male_____ Female_____

E-Mail_____ Marital Status: M S D W Employed by:_____

EMERGENCY CONTACT (someone other than a person that would be in your household):

Name_____ Relationship to patient_____
Address_____ City/State/Zip_____
Hm Phone(_____)_____ Wk Phone(_____)_____ Cell(___)_____

I certify that the above information is correct. I understand the office financial policies and procedures. I understand that High Mountain Healthcare reserves the right to add a 10% collection fee and any additional attorney fees that may apply to my account if it is forwarded to a collection agency.
Patient Signature_____

Patient Consent for Use and Disclosure of PHI

I hereby give my consent for High Mountain Healthcare providers (listed above) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by High Mountain Healthcare describes such uses and disclosures more completely.) I have the right to review the Notice of Privacy Practices prior to signing this consent. High Mountain Healthcare reserves the right to revise its Notices of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer, High Mountain Healthcare P.O.Box 2239, Blairsville, GA 30514, or by requesting a copy in person.

With this consent, the physicians and staff of High Mountain Healthcare may call my home or other alternative numbers I have provided and speak with me or leave a message on an answering machine, voice mail or with a family member or caregiver in reference to, but not limited to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing items including collection calls and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, High Mountain Healthcare providers may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and other patient statements. I have the right to request that High Mountain Healthcare providers restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow High Mountain Healthcare providers to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, High Mountain Healthcare, LLC may decline to provide treatment to me. I acknowledge that I have received the practice's Notice of Privacy Practices and have been provided an opportunity to review it.

_____
Print Patient's Name Print Legal Guardian's Name if applicable

_____
Patient or Legal Guardian's Signature Date