Ronna Alcartado, APRN
1701 County Rd Ste. H
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(775) 782-3933
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PATIENT INFORMATION FORM – ADULT

Patient Name: _____ Date of Birth: _____

Gender: ☐Female ☐ Male ☐ Transgender Patient Marital Status: ☐ Single ☐Married ☐Divorced ☐ Partner

Patient Mailing Address: _____

Patient Street Address (if different): _____

Patient Home Phone: _____ Patient Cell Phone: _____

Patient Social Security Number: _____

E-mail Address: _____

Patient Employer Name: _____ Work Phone: _____

Patient Emergency Contact Name: _____

Patient Emergency Contact Number: _____ Relationship: _____

Local Pharmacy Name & Location: _____

Mail Order Pharmacy: _____

Insurance Policyholder Name: _____

Insurance Policyholder SS# & DOB: _____

OK to leave detailed message at home? ☐Yes ☐No
OK to leave detailed message on cell? ☐Yes ☐No
OK to text/email appointment confirmation? ☐Yes ☐No

Race: ☐Asian ☐ Native Hawaiian ☐ African American ☐ White ☐ Hispanic ☐ Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic/Latin ☐ Not Hispanic

Primary Language: ☐ English ☐Spanish ☐Indian (including Hindi and Tamil) ☐ Russian ☐ Other

Translator Required: ☐Yes ☐ No

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Mental Health
New Patient Intake

(Form must be completed and returned at least 48 hours prior to scheduled appt, or appt will be cancelled)

NAME: **DATE OF BIRTH:**

Tell us why you are seeking care?

Who referred you?

SOCIAL HISTORY

Where were you born, raised, who raised you?

Do you have brothers or sisters? Gender and ages?

Relationships (married, divorced, single, living with partner):

Do you have children? Gender and ages?

Do you live in a apartment, house, condo, other?

Who do you live with?

Did you finish high school?

Highest level of education?

What do you do for a living to earn money? How many hours per week?

PSYCHIATRIC HISTORY

Any previous diagnoses? When and by whom?

Have you ever had a psychiatric hospitalization? When? Where? Why?

Have you ever seen a therapist?

Have you ever had suicidal thoughts or ever attempted suicide? Ever tried to harm another person?

History of psychiatric medications? Name, dose and diagnosis for each medication.

FAMILY HISTORY

Family history of mental illness? Which family member(s) and what was the diagnosis?

Were you adopted?

DEVELOPMENTAL HISTORY (For pediatric patients only)

Pregnancy with the person being seen today (Normal, complications, pre-term labor, etc):

Labor and Delivery (Normal, early, complications, etc):

Did the patient meet developmental milestones (walking, talking, potty training, reading)?

MEDICAL REVIEW OF SYSTEMS

Allergies to medication or food? If so, please include type of reaction?

History of medical diagnoses?

Current medications (including over the counter):

Do you have a primary care physician? Name? Last seen? Recent labs?

History of surgeries, hospitalizations?

Do you have any of the following symptoms/illnesses (Please circle):

Headaches Weakness arms or legs Concussion/head injury Seizures

Tingling/Numbness Frequent Skin Rashes Easy Bruising Sores in Mouth

Frequent Upper Respiratory Infections Trouble Swallowing Hearing Loss

Vision Difficulty Anemia Diabetes Type 1 or 2 Hypothyroidism

Hyperthyroidism Heart Palpitations Chest Pain Heart Arrhythmia

Heart Murmur Low or High Blood Pressure Other Heart Issues

Shortness of Breath Asthma COPD Frequent Constipation or Diarrhea

Frequent Urination Frequent Thirst Frequent Hunger

Trouble Urinating Frequent Aches and Pains Arthritis

Autoimmune Disorder Inflammatory Disease

Do you have any of the following symptoms (Please circle):

Depression Anxiety Panic Attacks Trouble concentrating

Poor Memory Difficulty functioning at school or work Poor sleep

Poor appetite Recent weight loss or gain Low energy Irritability

Trouble in large crowds Obsessions/compulsions

Seeing things that others can't see or hear Trouble making friends

Trouble talking to people Need for things to stay the same or predictable

Suspended or expelled from school Trouble with the law

Getting in fights at school Feeling out of control Nightmares

Bad memories popping into your head when you don't want them to

SUBSTANCE USE

Have you ever tried any of the following (Please circle):

Cannabis/Marijuana Opioids Tobacco Vaping

Methamphetamines Heroine Cocaine Mushrooms

Acid Large Amounts of caffeine Other

Alcohol

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Patient Cancellation and No-Show Agreement

New Patients,

Due to the nature of these appointments, it is imperative that you show up for your scheduled appointments. If you are not able to make your scheduled appointment times, it is your responsibility to call the office 24 hours or more in advance to cancel/reschedule your appointment(s), otherwise, you will be considered a no-show, and you will be charged a $25 fee.

Also, clients that no-call, no-show their first visit, the psychiatric evaluation that is scheduled for one hour, will not be allowed to reschedule the missed appointment.

For existing clients, after (2) no-shows, you will receive a letter informing you that your scheduling privileges have been suspended for 6 months.

We realize that an emergency may occur, and you may not be able to notify us. We will discuss that situation with you when it happens.

Thank you for working with us to ensure that services are provided to all of our patients in the best possible way.

Acknowledgement of Cancellation & No-Show Agreement

Signed_____ Date_____

Print Name_____

If PATIENT is a minor Print Name_____

Date of Birth_____

Mountainview Medical Associates

Patient Name: _____ Date: _____

E-PRESCRIBE CONSENT

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Mountainview Medical Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, hereby provide informed consent to Mountainview Medical Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

FINANCIAL AGREEMENT:

I understand that although I may own one or more insurance policies, I, not the insurance companies, am responsible for payment of all charges incurred in my treatment by Mountainview Medical Associates, and any co-payment will be paid TODAY.

I hereby authorize the release of any information acquired in the course of my examination or treatment to legal counsel, the insurance companies I have insurance through, and/or physicians to who I may agree to see at the request of Mountainview Medical Associates. I further authorize Mountainview Medical Associates to obtain medical information from any source deemed necessary for my treatment.

I hereby authorize and assign any payments directly to Mountainview Medical Associates for any surgical and/or medical benefits otherwise payable to me for services, not to exceed the contracted rate for those services. My consent in hereby granted to use this original or a copy as equally valid authorization.

In an effort to serve you better, it is important that you understand that it is your responsibility:

- **To know your insurance.**
- **To know if Mountainview Medical Associates is a contracted provider for your insurance.**
- **To know if you need prior authorization for procedures.**
- **To know if procedures (x-rays, labs, etc.) have to be done at a specific facility.**
- **To know if you have a co-payment, a yearly deductible, and if that deductible has been met.**

There are hundreds of insurance companies and it is not possible for our staff to know the specific requirements of each policy.

HIPAA

I, _____ (print patient/guarantor name) hereby acknowledge that I have access to a paper copy of practice's notice of privacy practices.

If a family member or friend calls or comes into the office requesting information regarding your current condition or any account related issues, who may we release this information to?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient/Guarantor Signature _____ Date: _____

For Office Use Only

☐ Acknowledgment refused:
Describe efforts to obtain signature:
State patient's reason for refusal:

Employee Signature: _____ Date: _____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: _____ **Date of Birth:** _____
Last First Middle

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct my health care provider:

Name: _____

Address: _____

Fax Number: _____ Phone Number: _____

to disclose my health information during the term of this Authorization to the recipient that I have identified.

Recipient: Name of person or class of persons to whom my health care provider may disclose my health information:
Mountainview Medical Associates 1701 County Rd Ste. H, Minden, NV 89423 (F) 775-782-3933 (F) 775-782-1127.

Purpose: I understand that the specific purpose of the Authorization is at the request of the patient.

Information to be disclosed: This authorization permits the above provider to disclose the following medical records:

☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental, or physical condition and any treatment received by me **

☐ All of my health information described above except for the following:

_____

☐ Only the following records or types of health information: (insert dated of treatment, types of treatment, or other designation:

_____

Terms: This authorization is to remain in place until the provider fulfills this request.
Refusal to sign/right to revoke: I may refuse to sign or may revoke this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment by my health care provider.
Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Officer at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Print Name: _____

Signature of Witness: _____

** NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law or mental health records that are protected by the Lauterman-Petrie-Sheet Act.