Blue Mountain Clinic
FAMILY PRACTICE

Patient Agreement

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION: ALL PROFESSIONAL FORMS RENDERED ARE CHARGED TO THE PATIENT; NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDSLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF BLUE MOUNTAIN CLINIC ARE PAYABLE AT THE TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU “THE PATIENT” AND/OR GUARANTOR OF “YOUR CHILDREN”.

I HEREBY AUTHORIZE BLUE MOUNTAIN CLINIC TO FURNISH INSURANCE COMPANIES OR THE REPRESENTATIVES INFORMATION CONCERNING MYSELF AND OR MY DEPENDANT’S ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO BLUE MOUNTAIN CLINIC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

I HEREBY AUTHORZIE AND RELEASE THE CLINICIANS AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENTS, PHYSICAL EXAM, XRAY, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE. I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORDS TO ANY PERSON OR CORPERATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL FOR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKER’S COMPENSATION CARRIERS, WELLFARE FUNDS, OR THE PATIENT’S EMPLOYER.

PATIENT INFORMATION CONSENT: I UNDERSTAND THAT BLUE MOUNTAIN CLINIC MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT, FOR OBTAINING PAYMENT OF SERVICES, AND FOR THE PURPOSES OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSED OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS. I AUTHORIZE BLUE MOUNTAIN CLINIC TO OBTAIN/HAVE ACCESS TO MY MEDICAL HISTORY.

I UNDERSTAND THAT MY CONSET IS NOT NEEDED IF THE LAW REQUIRES BLUE MOUNTAIN CLINIC TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE SUSPECTED ABUSE, COMMUNICABLE DISEASE, AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTANDTHAT I HAVE A RIGHT TO REVIEW THE BLUE MOUNTAIN CLINIC PRIVACY NOTICE, TO REQUEST RESTRISTCTIONS BE PUT ON THE USE OF MY INFORMATION AND REVOKE MY CONSENT AT A LATER DATE IN WRITING.

I UNDERSTAND THAT IF I WITHHOLD CONSET FOR THE USE OF MY MEDICAL INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, BLUE MOUNTAIN CLINIC MAY REFUSE TO UNDERTAKE MY CARE.

I, AND THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS, ADMINISTRATION OF ANY NEEDED ANESTHETICS, ADMINSTRATION OF ANY CDC RECOMMENDED VACCINATIONS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATIONS, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGEMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEE. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

I UNDERSTAND THAT BLUE MOUNTAIN CLINIC MAY REFUSE CARE DUE TO NO SHOWS, LACK OF PAYMENT, DISRESPECT TO STAFF, OR DESTRUCTION/THEFT OF PROPERTY.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINSTRATION AND ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I SIGNED THE BENEFITS PAYABLE FOR THE SERVICES TO BLUE MOUNTAIN CLINIC.

HIPPA ACKNOWLEGMENT: I HAVE RECEIVED AND READ THE BLUE MOUNTAIN CLINIC NOTICE OF PRIVACY PRACTICES. IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE BELOW LISTED PERSON(S) TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME.

Patient (or Guardian) Signature DATE