Basic Clinic Info:

1. In order to best serve our established clients, we do not prescribe pain medication or ADHD medication for new patients.
2. We are open Monday-Thursday 8:30-5:30, and Friday from 8-1.
3. We are closed on all major holidays.
4. We require 24-48 hours notice for all medication refill requests. Please contact your pharmacy or send a request through your patient portal.
5. Our phone lines are closed for lunch from 12:45-1:45 pm. If you leave a message at any time, we will get back to you within 48 hours. Please do not leave multiple messages as this delays the amount of time it takes to promptly return calls.
6. Lab hours are Monday-Friday 8:30-12, and Monday-Thursday 2-4. Please call ahead to ensure we have available staffing.
7. We are an independent, non-profit family medicine clinic that receives NO government funding, and therefore do not offer a sliding fee scale.

610 N California St, Missoula, MT 59802
Phone: 406.721.1646
Fax: 406.543.9890
Website: www.bluemountainclinic.org
Email: info@bluemountainclinic.org
frontdesk@bluemountainclinic.org

BLUE MOUNTAIN CLINIC

610 N. California St. Missoula, MT 59802

PATIENT REGISTRATION

ALL INFORMATION IS CONFIDENTIAL

Legal Name(*please include middle initial and maiden name*) ______________________________

Name you would like us to use: ______________________________ Your Pronouns ______________

Sex on Legal Documents (please circle one)* Female Male ______________ Gender ______________________

*While we recognize a number of genders and sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and legal correspondence. If your name and pronouns are different from these, please let us know so we may address you appropriately and respectfully.

Birthdate ________/________/________ Social Security # ______-______-______

Physical Address: ____

Mailing Address: ____

Email Address: ____

Home Phone ______________________ ok to leave a message? ☐ Yes ☐ No

Cell Phone ______________________ ok to leave a message? ☐ Yes ☐ No

Work Phone ______________________ ok to leave a message? ☐ Yes ☐No

Can we identify ourselves as Blue Mountain Clinic when calling? ☐ Yes ☐ No

Occupation: ______________________ Employer ______________________ Phone ______________

Emergency Contact: ______________________ Relationship to patient: ______________ Phone ______________

Blue Mountain Clinic may verbally exchange health information with person(s) or organization(s) named below: ______________

____

We will send certain correspondence, such as bills, to your mailing address. How would you prefer to receive other types of written correspondence? Patient Portal ☐ Letter ☐

Required by government mandate (although you may refuse):

Language: ______________ Race: ______________ Ethnicity: ☐Hispanic ☐Non-Hispanic

Marital Status: ☐single ☐partner ☐married ☐separated ☐divorced ☐widowed

What is the highest degree or level of school you have completed?

☐less than high school diploma ☐high school diploma or GED ☐some college, but no degree

☐Associates Degree (AA, AS) ☐Bachelor's Degree (BA, BBA, BS) ☐Master's Degree (MA, MS)

☐Professional Degree (MD, DO, DDS, JD) ☐Doctorate (PhD, EdD)

Primary Insurance:

Plan Name: ____

Policy Number: ______________________ Group Number: ______________

Policy Holder Name: ______________________ Policy Holder DOB: ______________

Patient's relationship to policy holder: ______________________

Secondary Insurance:

Plan Name: ____

Policy Number: ______________________ Group Number: ______________

Policy Holder Name: ______________________ Policy Holder DOB: ______________

Patient's relationship to policy holder: ______________________

CREDIT AND BILLING POLICY

Thank you for choosing Blue Mountain Clinic for your health care needs! Please take a moment to read over our credit and billing policies.

INSURANCE PAY - We require all co-payments to be made at the time of service, and payment in full for any deductibles and services not covered by your policy. It is *your* responsibility to ensure that the Clinic has your correct insurance information and to make sure that the services provided are a benefit of your contract. If your insurance has a Preferred Provider Network, you will be responsible for verifying participation of any physician involved in your care. If you have a secondary insurance we will submit the claims for you. *For your convenience we accept cash, checks, credit cards, and We Trade.*

It is important that you understand that your contract with an insurance company is between you and them; therefore, the ultimate responsibility for payment belongs to you. Each plan is different and filing with insurance is no guarantee that services will be paid for.

PRIVATE PAY - Payment in full is due at the time of service.

****** If your medical care is due to an injury and/or an accident (i. e. Workers Compensation or Motor Vehicle Accident), please have ready the claim number, name of claim adjuster, phone number, correct billing address and date of injury.*****

We reserve the right to charge interest on any account over 60 days.

LAB POLICY - Blue Mountain Clinic is able to offer many lab tests in house. There is no assurance that lab work will be covered by your insurance. Certain tests (such as pap tests, pathology, and some blood work) must be sent to labs outside of Blue Mountain Clinic. We will forward your insurance information, although we cannot guarantee what will be covered, nor what the exact charge will be. Please be aware you will receive a separate bill from these other facilities. You must contact the outside lab directly if you have any billing questions.

COLLECTION POLICY - Our collection policy consists of an initial statement being billed following payment by insurance. If no payment is received, a second statement will be sent, and considered past due. Should no payment be made during that time, a third statement will be sent with a final notice letter. You will have 10 days to make payment arrangements. If no payment or contact is made you will be turned over to collections. **ALL THIRD PARTY COLLECTION FEES WILL BE YOUR RESPONSIBILITY**. These fees may include agency fees, attorney fees, and a collection fee of up to 50% of the account total added to the balance.

DISCHARGE POLICY- It is our policy to discharge patients from our practice who have been turned over to collections.

Because Blue Mountain Clinic's healthcare philosophy centers around our clients, it is of the utmost importance that you come to your appointments. It is our policy that you cancel at least 24 hours prior to your appointment. If you do not, you may be subject to **a $25.00 fee, and may not be able to continue your care at BMC.*

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

______________________________	______________________________	______________
Signature of Responsible Party	*Print Name*	*Date*

BLUE MOUNTAIN CLINIC

610 N. California St. Missoula, MT 59802

ACKNOWLEDGEMENT AND AUTHORIZATION

Privacy Policy: Blue Mountain Clinic cannot release your personal health information without your express, written consent.

Cancellation/No Show Policy: Blue Mountain Clinic requests 24 hours' notice for cancelling or rescheduling an appointment. After the second no show, you may be responsible for a $25 no show fee. After the third no show, we may discharge you from our practice and recommend seeking care elsewhere.

Please initial next to each item, then print and sign on the indicated lines.

____ I have read and understand the HIPAA/Privacy Policy for BLUE MOUNTAIN CLINIC INC.

____ I have read and understand the Financial Policy for BLUE MOUNTAIN CLINIC INC.

____ I hereby assign my insurance benefits to be paid directly to the healthcare provider.

____ I authorize BLUE MOUNTAIN CLINIC INC to release medical information required to process my claim.

____ I authorize BLUE MOUNTAIN CLINIC INC to obtain/have access to my medication history.

____ I authorize my provider's office to contact me by mobile phone.

____

Patient's Name

____

Parent or Guardian's Name (if applicable)

____

Signed

____

Date

BLUE MOUNTAIN CLINIC
610 N. California St. Missoula, MT 59802
MEDICAL HISTORY
ALL INFORMATION IS CONFIDENTIAL

Patient #____________________
Date________________________

Legal Name(*please include middle initial and maiden name*)

Name you would like us to use: Your Pronouns:

Sex on Legal Documents (please circle one)* Female Male Gender

Birthdate / / Social Security # - -

Have you ever been a patient at Blue Mountain Clinic before?____Yes (date__________) ____No
Reason for visit____

FAMILY MEDICAL HISTORY: (Include parents and siblings)

Heart Disease ______________________ Stroke______________________
Diabetes______________________ Aortic Aneurysm______________________
High Blood Pressure______________________ Other______________________
Cancer: ☐Colon_________________ ☐Breast______________________ ☐Other Cancer ______________________

PERSONAL MEDICAL HISTORY: (Include past and present, space on back if needed)

Age_____Height_____Weight_____Blood type_____Date of last Physical Exam______________________
Allergies to Medication______________________
Other allergies______________________
Current Medications & Doses (attach list if needed) Pharmacy of Choice______________________

Name of medication	Strength in mg/ml	Number of times a day taken

☐ HIV positive ☐ Hepatitis C positive

Specialists you currently see: ______________________

	Yes	**Comments/Dates**
Habits: Alcohol	_____	______________________
Tobacco	_____	______________________
Respiratory: Lung/Sinus problems, Asthma	_____	______________________
Cardiac: High Blood Pressure, Heart Murmur, High Cholesterol, Blood Clotting disorder	_____	______________________
Gastrointestinal Problems: Liver, Stomach, Gallbladder, Bowel, Heartburn	_____	______________________
Joint Problems: Pain, Swelling, Injury Arthritis	_____	______________________
Genital/Urinary Problems: Bladder, STD's Kidney, Sexual Function, Other	_____	______________________
Hormonal: PMS, Diabetes, Thyroid, Other	_____	______________________
Neurologic: Migraines, Seizures, Other	_____	______________________
Psychologic: Depression, Anxiety, Other	_____	______________________
Illness, Injuries, Surgeries, Hospitalizations:	_____	______________________

REPRODUCTIVE HISTORY:

Are you currently sexually active? ___Yes ___No
Do you consider yourself at risk for any sexually transmitted infections?____
Have you undergone any sexual reassignment surgery? ___ Yes ___ No
If yes please list ____

IF APPLICABLE: ☐ N/A

Do you have a current method of Birth Control?____
How long have you used?______________________ Problems?__________________________________
Are you postmenopausal? ___ Yes ___ No
Have you had a hysterectomy? ___ Yes ___ No
What was the first day of your last menstrual period?_____________________Date of last Pap Smear_____________
Have you ever had any of the following:

1. Abnormal Pap Smear ___Yes ___No Dates & Treatment_________________________________
____

2. History of uterine abnormality, fibroid, infection or surgery ___Yes ___No
Comments, including dates and treatment____
____

3. Spotting or bleeding since your last period ___Yes ___No

Do you have regular periods? ___Yes ___No Problems____

Do you think you might be pregnant now? ___Yes ___No
Have you had intercourse without birth control since your last period? ___Yes ___No

Previous pregnancies? ___Yes ___No
Live births #____ Abortions#____ Miscarriages#____ Still births# ____
Ectopic# ____ Cesarean# ___ Multiple births____
Deceased children/cause____

Date last pregnancy ended (regardless of how ended)_______________________________________
Dates and complications, if any, of pregnancies____

PREVENTION (50 YEARS OR OLDER)
Bone dexa scan: Year_________ Result____
Colon Cancer test:

- Colonoscopy Year______ Result____
- Stool Year_____ Result____

Abdominal Aortic Year_______ Result____
Hepatitis C Screen Year______ Result____
Shingles Vaccine Year___________Pneumonia Vaccine Year___________
Have you had falls in the last month? (over 50 yo) __ Yes __ No How many? ____
Do you have a health care power of attorney or code status designated? __ Yes __ No
Would you like advice on this today? __ Yes __ No
Do you have urinary incontinence? __ yes __ No

*While we recognize a number of genders and sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and legal correspondence. If your name and pronouns are different from these, please let us know so we may address you appropriately and respectfully.

BLUE MOUNTAIN CLINIC
FAMILY PRACTICE

610 N California St ·Missoula, MT 59802
(406)721-1646 · 800-727-2546 · FAX (406)543-9890
www.bluemountainclinic.org

Authorization for Release of Information

Patient Name____
Last First Middle Other Name

Date of Birth______/_____/______SS#________/______/________Phone_____________________
Address____City________________________State_____Zip____________

☐ I authorize Blue Mountain Clinic **to release information to** the following provider:	**OR**	☐ I authorize Blue Mountain Clinic **to obtain information from** / I authorize this provider to release information to Blue Mountain Clinic:
Name of provide ror facility		*Name of provider or facility*
Address		*Address*
City, State, Zip code		*City, State, Zip code*
Phone number, fax number (include area code)		*Phone number, fax number (include area code)*

OR ☐ **I am requesting a copy of my records for my own use.**
Please_________Fax ________Mail_________Contact me to pick up records from the clinic

Information to be released:

___Progress (Visit) Notes
___Lab Reports
___X-Ray Reports
___All Records

__Other (please describe): ______________________________
__Records relating to a specific illness or injury:
________________________________dates: ___________
(specify illness or injury)

Please specify the reason for disclosure:

___Changing Physicians ____Consultation/Second Opinion ____Continuing Care
___Legal ____School ____Insurance
___Other (please specify)____

1. I understand that this authorization will expire 180 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by my provider, my health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I have signed it.

Signature of Patient (or representative)____Date__________

If representative, relationship to patient (i.e. parent, guardian,etc.) ____