HEAVENS PEAK
HEALTH CARE

PO Box 2060
1035 9th Street West
Columbia Falls, MT 59912

Phone: (406)897-2000
Fax: (406)897-2261

Website: heavenspeakhealthcare.com
Email: heavenspeakhealthcare@gmail.com

NEW PATIENT DEMOGRAPHICS

Patient Name _____ Social Security Number _____-_____-_____
Last First MI

DOB ____/ _____/ _____ Sex: M ___ F ___ Marital Status _____ Ethnicity _____

Mailing Address _____ City _____ State _____ Zip Code _____

Physical Address _____ City _____ State _____ Zip Code _____

Home/Cell Phone _____-_____-_____ Work Phone _____-_____-_____

Patients Occupation/Employer _____ How did you hear about us ? _____

Email _____

Preferred Pharmacy _____ Location _____

Insurance Information

Primary Insurance _____ Policy _____ Group # _____

Subscriber's Name _____ DOB ____/_____/_____ Sex: M ___ F ___

Relationship to subscriber _____

Secondary Insurance _____ Policy _____ Group # _____

Employer _____

Emergency Contacts

Name _____ Relationship _____ Phone # _____-_____-_____

Name _____ Relationship _____ Phone # _____-_____-_____

Consent and Autorization

I hereby give my consent for medical treatment. I further authorize the holder of medical or other information to release my government agency, or it's intermediary any information for this or a related insurance claim. I request that payment of authorized benefits insurance carrier, be made to this office that accepts assignment. I agree to pay all co-pays/deductibles or other authorized charges not covered by my insurance carrier. I understand that I am responsible for notifying this office of any changes in insurance coverage or address.

Printed Name _____

Signature _____ Date _____/_____/_____

ADULT HEALTH QUESTIONAIRE

Patient Name: _____ DOB: ____/____/____

Family History Key: M-Mother/ F-Father/MG- Maternal Grandparent/PG-Paternal Grandparent/B-Brother/S-Sister

Breast Cancer _____ Diabetes _____ High BP _____ Prostate Cancer _____ Stroke _____
Colon Cancer _____ Heart Disease _____ Osteoporosis _____ Other Cancer _____

Prevention Key: Enter Dates

Bone Density Test _____ EKG _____ Lab/Blood Test _____
Chest X-ray _____ Eye Vision Test _____ Mammogram _____
Colon Cancer Screen _____ Hearing Test _____ Pap Smear _____

Advanced Directives Living Will ☐ Yes ☐ No Durable Power of Attorney for Health Care ☐ Yes ☐ No

Drug Allergies (please indicate and provide medication reaction) ☐ None

Reaction:
Reaction:
Reaction:

Current Medications with Strength/Dose (include vitamin/herbal supplements)

Caffeine ☐ None ☐ Yes # of cups per day _____
Tobacco Use ☐ Non-Smoker ☐ Ex-Smoker Year Quit _____ ☐ Smoker packs per day _____ for how many years_____
Alcohol Use ☐ None ☐ Ex-Drinker Year Quit _____ ☐ Yes # of drinks per day _____ # of drinks per week _____

Past Medical History (check all symptoms/disease that apply to your PAST HEALTH)

☐ Abdominal Pain	☐ Bone Fracture	☐ Depression	☐ High Blood Pressure	☐ Sexually Transmitted Disease
☐ Abnormal Bleeding	☐ Cancer	☐ Diabetes	☐ Indigestion	
☐ Abnormal Pap Smear	☐ Chest Pain	☐ Fatigue	☐ Liver Disease	☐ Shortness of Breath
☐ Anxiety/Panic Attacks	☐ Chronic Anemia	☐ Glaucoma	☐ Osteoporosis	☐ Stomach Ulcers
☐ Asthma/Emphysema	☐ Chronic Back Pain	☐ Hearing Difficulties	☐ Pelvic Pain	☐ Stroke
☐ Breast Disease	☐ Chronic Cough	☐ Heart Disease	☐ Pneumonia	☐ Thyroid Disease
☐ Blood Transfusion	☐ Chronic Headaches	☐ Hepatitis	☐ Prostate Disease	☐ Tuberculosis
Date: _____	☐ Colon Disease	☐ Hernia	☐ Seizure/Epilepsy	☐ Urinary Difficulties

Women Only

Date of last menstruation ___/___/____ Period every ____ days
☐ Heavy ☐ Irregular ☐ Spotting ☐ Pain ☐ Discomfort ☐ Bloating
Age at onset of menstruation: _____
Number of Births: _____ ☐ Pregnant ☐ Breastfeeding
☐ Hot Flashes ☐ Sweating at Night ☐ Blood in your urine
☐ Issue controlling urination ☐ Bladder Infection ☐ Kidney Infection
Date of last pap smear ___/___/_____
Date of last rectal exam ___/___/_____

Men Only

How many times a night do you urinate? _____ ☐ Pain
☐ Burning ☐ Blood ☐ Kidney Infection ☐ Bladder infection
Has the force of urination decreased? ☐ Yes ☐ No
Any problem emptying bladder completely? ☐ Yes ☐ No
☐ Difficulty with Erection ☐ Difficulty with Ejaculation
☐ Testical Swelling ☐ Testical Pain
Date of last prostate exam? ___/___/_____
Data of last rectal exam? ___/___/_____

Past Surgical History (Please indicate YEAR of surgery) ☐ None

Appendectomy _____ Breast _____ Colon _____ Heart Bypass _____ Hysterectomy _____ Tonsillectomy _____
Back/Spine _____ Cataract _____ Gallbladder _____ Hernia _____ Prostate _____ Other(s) _____

Other Hospitalization(s)

Year : _____ Reason: _____ Hospital Name: _____
Year : _____ Reason: _____ Hospital Name: _____

Religious/Cultural Beliefs

Do you have any religious or cultural practices which restrict the foods you eat or the medical treatment you receive?

_____

Do you have any special learning or communication needs? _____

HEAVENS PEAK
HEALTH CARE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, _____ (Name of Patient), hereby voluntarily authorize the disclosure of information from my health record.

Patient Name: _____ DOB: ____/____/_____ SSN: ____-____-_____

Release Of Records From:

_____ (____)____-_____ (____)____-_____

Health Provider/ Facility Name | Telephone Number | Fax Number

_____ _____, _____ _____

Street Address | City | State | Zip Code

Information Requested:

Summary information for prior 2 years of clinic notes, history and physical, operative reports, consultations, discharge summaries, laboratory results, pathology reports, EKG/EEG/EMG reports, immunization records, medication records, and radiology reports.

Purpose of Release:

Continued Care

The information is to be provided to: **Heavens Peak Health Care**, **PO Box 2060**, **Columbia Falls, MT 59912**, **Phone: (406)897-2000**, **Fax: (406)897-2261**, **Interoffice Mail By Courier**

1. I understand that this authorization will expire one year from the date of request.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Heavens Peak Health Care in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.

_____ ___/___/_____

Patient's Signature or Patient's Representative | Date

_____ ___/___/_____

Printed Name of Patient's Representative | Date

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

Under HIPAA with patients' written request, records must be provided within 30 days of a request.

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.

HEAVENS PEAK
HEALTH CARE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES/USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If the terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ ____/____/____

Signature of Patient or Legal Representative — Date

_____ _____

Printed Name of Patient — Legal Relationship to Patient

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give Heavens Peak Health Care permission to share my health information with:

1. Name _____ Relationship _____ Phone _____
2. Name _____ Relationship _____ Phone _____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell number that I authorize to receive text messages for appointment reminders and general health information

( ) _____ Please Initial _____

The email I authorize to receive text messages for appointment reminders and general health information is

_____ Please Initial _____

OR

I decline to receive communication via text. Please Initial _____

I decline to receive communication via email. Please Initial _____

Revocation- Use this area to document revocation of a previous form of communication.

I hereby revoke my request to receive future appointment reminders or healthcare updates via text. _____

I hereby revoke my request to receive future appointment reminders or healthcare updates via email. _____

Patient Signature _____ Date Requested: ____/____/____

Reminder-Keep information to the minimum necessary and encrypt emails and texts whenever possible

HEAVENS PEAK
HEALTH CARE

Appointment Attendance Policy

Our office has identified that appointment no shows and late arrivals hamper our ability to successfully meet the treatment needs of our patients. We feel that each patient's reserved appointment time is important. A missed or late arrival greatly impacts your continued care.

Please read and sign the following document indicating that you are aware and will comply with the following policies:

We understand that situations occasionally arise that may make it impossible to attend a previously scheduled appointment. We kindly request that you notify our office by phone (406)897-2000 no later than **24 hours** in advance if you are unable to attend your scheduled appointment. Prompt notification allows you to quickly reserve another appointment and enables another patient to take advantage of your original appointment time.

Failure to comply with the required 24-hour notification will result in the following no show/cancellation fees:

- $25 - 1st missed office visit
- $50 - 2nd missed office visit
- $75 - 3rd missed office visit
- Discharge after 4th no show in 6 months-1 year

We understand that situations occasionally arise that make it impossible to be prompt to a scheduled appointment. We kindly request that you notify our office by phone (406)897-2000 if you anticipate a late arrival. Each appointment is scheduled by identifying the patient's individual needs and necessary treatment time. Often these needs cannot be met in a shortened time frame.

If you are more then 7 minutes late for a 15 minute appointment or 15 minutes late for a 30 minute appointment, you will have to reschedule. Patients need to arrive 15 minutes prior to appointment time.

Please Initial _____

We will attempt to schedule you the same day, but only if we can do so without impact to another patient's reserved appointment time. Typically, the late arrival to an appointment will not be able to accommodated that same day.

The appointment will need to be rescheduled and this becomes a missed appointment and therefore the above-mentioned fee applies.

_____
Patient Printed Name

_____ _____
Patient Signature Date