Premier Mountain Adult Medicine
5300 S. Sutter, STE 12
Show Low, AZ 85901
Phone: 928-251-2541 / Fax: 833-450-5183

Patient Intake Form

Patient Demographics

Name:	DOB:	Male or Female
Address:		Primary Ph#
Address:		Alt Ph #

Leave Message Okay:	☐ Yes	☐ No	Text Reminder Okay:	☐ Yes	☐ No

Emergency Contact:	Relationship to You:
Consent to call regarding test results & medical care: Y or N	Phone #:
Emergency Contact:	Relationship to You:
Consent to call regarding test results & medical care: Y or N	Phone #:
Email Address?	

Primary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	

Secondary Insurance

Insurance Name:	
Member ID:	Group Number:
Insurance Phone#:	Effective Date:
Policy Holder's Employer:	Phone #:
Relationship to Insured:	

Medical History

Primary Care Provider:	Phone #:
List all current physicians and/or practitioners you currently use.	
Name	**Speciality**

Current Medical Issues/ Chronic Illness / Diagnosis:

Pain

Are you experiencing Pain? ☐ Yes ☐ No	Location of Pain?
How Long?	Medication(s) Used for Pain?

Pain Level Today:

Mild ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Severe

Medications

Preferred Pharmacy & Location:

List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed or turn paper over.*

Medication	Dose	Frequency	Prescribed By

Surgeries/Hospitalizations

Type of Surgery / Hospitalization	Date

Medical Information

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Weight: Height: Appetite: ☐ Good ☐ Fair ☐ Poor

List any vaccines you've had in the last year:

Allergies:

Health Maintenance History			
Yearly Physical	Date:	☐ Normal	☐ Abnormal
Mammogram	Date:	☐ Normal	☐ Abnormal
Blood Work	Date:	☐ Normal	☐ Abnormal
Colonoscopy	Date:	☐ Normal	☐ Abnormal
Bone Density	Date:	☐ Normal	☐ Abnormal
EKG/Cardiac:	Date:	☐ Normal	☐ Abnormal

Women's Health History		
Date of Last Menstrual Cycle:		Age of First Menstruation:
Pregnancy Complications:	Possibly Pregnant:	☐ Yes ☐ No
Number of Pregnancies:	Number of Live Births:	Age of Menopause:

Please check any condition you currently have OR have ever had in the past (include childhood illnesses).

- ☐ None
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Blood Clot
- ☐ Anemia
- ☐ Depression
- ☐ Osteoporosis
- ☐ Pins or Metal Implants
- ☐ Arthritis
- ☐ Epilepsy
- ☐ COPD
- ☐ Anxiety
- ☐ Gout
- ☐ Seizures
- ☐ Hepatitis
- ☐ Stroke
- ☐ Concussion
- ☐ STD
- ☐ Hernia
- ☐ Visual Dysfunction
- ☐ Neurologic Disorder
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Low Blood Pressure
- ☐ Fibromyalgia
- ☐ Pacemaker
- ☐ Heart Problem
- ☐ Infectious Disease
- ☐ Alcoholism
- ☐ Sleep Problems
- ☐ Leg Swelling
- ☐ Breathing Problems
- ☐ Migraines/Headaches
- ☐ Thyroid Trouble
- ☐ Lupus
- ☐ Ulcers
- ☐ High Blood Pressure

Additional Information of other illness:

Have you experienced any of these symptoms recently? (Check all that apply)

- ☐ Chest Pain
- ☐ Pain with Meals
- ☐ Nausea/Vomiting
- ☐ Poor Balance/Falls
- ☐ Difficulty Swallowing
- ☐ Unusual Pain w/Menstruation
- ☐ Unexplained Weight Gain/Loss
- ☐ Self-Injury
- ☐ Dizziness
- ☐ Vision Changes
- ☐ Memory Problems
- ☐ Unusual Weakness
- ☐ Shortness of Breath
- ☐ Change in Bowel Habits/Control
- ☐ Change in Bladder Habits/Control
- ☐ Suicidal Ideation
- ☐ Fever/Chills/Sweats
- ☐ Difficulty Speaking
- ☐ Numbness/Tingling
- ☐ Change in Appetite
- ☐ Confusion/Brain Fog
- ☐ Increased Pain at Night/Rest
- ☐ Other:

Family History

List health problems and causes of death, if applicable:

Relationship to You	Status	Age	Medical Problem
Father	☐ Living ☐ Deceased		
Mother	☐ Living ☐ Deceased		
Father's Father	☐ Living ☐ Deceased		
Father's Mother	☐ Living ☐ Deceased		
Mother's Father	☐ Living ☐ Deceased		
Mother's Mother	☐ Living ☐ Deceased		
Brother	☐ Living ☐ Deceased		
Brother	☐ Living ☐ Deceased		
Sister	☐ Living ☐ Deceased		
Brother	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		
Child	☐ Living ☐ Deceased		

Other family member information:

Social History

Do you or have you ever smoked Tobacco: ☐ Yes ☐ No	**Alcohol Use:** ☐ Yes ☐ No
If yes, how many packs a day:	If yes, how many drinks a day/week:
Number of years:	☐ Beer ☐ Wine ☐ Liquor
Any other forms of tobacco or nicotine including chewing tobacco, e-cigarettes and vaping? ☐ Yes ☐ No	
Illicit Drug Use: ☐ Yes ☐ No	Notes:
Cannabis Use: ☐ Yes ☐ No	

Exercise: Do you exercise regularly? ☐ Yes ☐ No	What kind of exercise? Duration: Frequency:	
Sleep: How many hours, on average do you sleep a night? #hour:	Trouble falling asleep? ☐ Yes ☐ No	Trouble staying asleep? ☐ Yes ☐ No
Is there anything else you would like us to know?		

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge. I authorize Premier Mountain Adult Medicine (PMAM) and any associates, assistants, and other health care providers it may deem necessary, to treat my medical concerns;

- I voluntarily consent to any and all health care treatment and diagnostic procedures provided by PMAM. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations by PMAM.
- I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with PMAM privacy practices.
- I authorize payment of medical benefits to PMAM or their designee for services rendered.
- I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.
- I have received a copy of the Notice of Privacy Practices.

______________________________	______________________________	__________
Signature	Printed Name	Date

NOTICE OF PRIVACY PRACTICES

(SHORT FORM SUMMARY)

This Notice is effective as of: 09/23/2013

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations: We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI: We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographics information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:
* public health reporting and oversight activities
* judicial, administrative, or law enforcement proceedings
* complying with workers' compensation laws
* communicatiing with your family and caregivers
* sending appointment reminders

You Have the Right to:

*Request certain restrictions on our use and disclosure of your PHI.
* Request communications from us by specific means or location.
* Inspect and copy your medical record.
* Ask us to correct the information in your medical record.
* Receive an accounting of disclosures of your PHI by our practice.
* Be notified in the case of a breach of unsecured PHI.

Contact Us:

Please inquire with any staff member should you have any questions, comments, or complaints; or to exercise any of your rights at Premier Mountain Adult Medicine.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received and have read the Notice of Health Information Practices for Premier Mountain Adult Medicine. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

PRINTED Name of Patient or responsible party

____ **Date:** ____________

SIGNATURE of Patient or Responsible Party

____

Cancellation Fee Policy

Premier Mountain Adult Medicine is committed to providing all our patients with exceptional care. When a patient cancels without giving notice, they prevent another patient from being seen. With that said – we understand that there are times when you must miss a scheduled appointment due to emergencies and/or obligations for work or family. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment schedule.

Therefore, ***if you need to cancel and/or reschedule an appointment you are required to call no later than 24 hours prior to the scheduled appointment time.*** If you need to cancel/reschedule a Monday appointment – you must call prior to close of business on the Friday before.

If an appointment is not cancelled at least 24 hours in advance of your scheduled appointment time you will be charged a thirty-five-dollar ($35) fee; this will not be covered by your insurance company and must be paid prior to your next visit. Multiple non-cancellation/No-show events in any given 6-month period may result in termination from our practice.

Late Arrival Policy

Premier Mountain Adult Medicine understands that delays can happen- however, we must try to keep the other patients and doctors on time. If a patient arrives 10 minutes or more past their scheduled appointment time, we will have to reschedule the appointment.

Patient printed name:

________________________________ **Date:** ________________

Signature of patient:

____

FINANCIAL POLICY

Welcome and thank you for choosing Premier Mountain Adult Medicine as your healthcare provider. We are committed to delivering the highest quality of care at the lowest possible cost. The following is a statement of our financial policy that we require you to read and sign prior to any services being rendered.

Please be aware that some, and perhaps all, of the services provided may be non-covered services that are not considered reasonable and necessary by your insurance carrier.

Participating Insurance Plans

For those plans with which we are participating providers, all co-pays and deductibles are due at the time of service. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card on file upon each visit. In the event that your insurance coverage changes to a plan with which we do not participate refer to the following paragraph.

Non-Participating Insurance Plans

For those plans with which we do NOT participate- we do not accept assignment of insurance benefits and we do not bill your insurance company. Payment(s) by cash or credit /debit card are expected at the time of service. Your policy is a contract between you and your insurance company.

Authorization to pay Benefits to Physician/Office

I hereby assign payment directly to Premier Mountain Adult Medicine for medical and/or surgical benefits- if any- otherwise payable to me for services provided at the clinic. Not to exceed my indebtedness to the clinic for those services. I understand that I am financially responsible for any charges for provided services not covered by my insurance, this includes charges that apply to co-insurance and/or deductibles – said charges are due at the time of service.

Authorization to Release Information

I hereby authorize Premier Mountain Adult Medicine to release any information acquired during my examination or treatment to my referring physician and/or my insurance company.

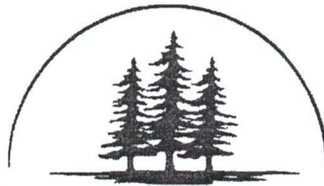
Account Balances

We will require that patients with outstanding balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the Office Manager with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Acknowledgement

I have read and understand the above Financial Policy and Benefits Authorization and agree to adhere to the provisions outlined herein.

Patient signature: ______________________________ **Date:** ______________



PREMIER MOUNTAIN

ADULT MEDICINE

MEDICAL RECORDS RELEASE

To ensure that your medical records are held in the utmost confidentiality, be as explicit as possible as to where you want them sent.

Name ______________________________ D.O.B. ______________________________

Address ______________________________ City ______________ State ______ Zip ________

Phone ______________________________

Transfer From ______________________________ Transfer To ______________________________

______________________________ ______________________________

______________________________ ______________________________

RECORDS TO BE RELEASED

Date From ____/____/____ Date To ____/____/____

[ ] Medical information related to ______________________________

[ ] Lab results/Xrays/Imaging ______________________________

[ ] Immunizations ______________________________

[ ] Visit notes related to ______________________________

I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent.

Please initial below if you **DO NOT** want any of the following records released. All applicable records will be released if nothing is marked.

_______ Drug and/or alcohol abuse, diagnosis, or treatment

_______ HIV/AIDS testing and/or treatment

_______ Psychiatric and/or mental illness care

_______ STD Test results and/or treatment

Signature ______________________________ Date ______________

Witness ______________________________ Interpreter if needed ______________________________

*Fee for printed paper copies: 1-30 pages $25, 1-60 pages $35, 1-100 pages $55, over 100 pages $100

Date: _________________________________

Name: ____DOB:_______________________

Full Address: ____

Cell Phone: ____________________________

By my signature below I do willingly request and consent to compounded Semaglutide, Vitamin B-12 injections. While proven successful in weight loss, I understand that there is no warrant or guarantee of results from use of Semaglutide weekly injections.

1. I understand that this is **NOT** Ozempic, Rybelsus, or Wegovy and is a compounded Semaglutide with Vitamin B-12 added. I understand that the medication is coming from a compounding pharmacy.

2. I understand that as part of this program I will be required to complete a Medical History and meet with a Medical Provider to determine my candidacy. I understand that initial blood tests may be required in order to rule out any conditions that would disqualify me from the program or require any prior treatment before starting the program. I agree to immediately report any problems that might occur to Premier Mountain Healthcare, as well as my Primary Physician during the treatment program.

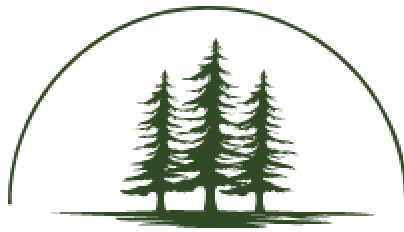
3. I understand that there could be risks involved, as there are with all medications. Failure to comply with the dosage recommendation and dietary restrictions could alter the weight loss results.

4. I agree that I am, and will be, under the care of my primary medical provider for all other medical conditions.

5. I understand that treatments for weight loss are rarely covered by insurance companies. We will bill your insurance for this program with the exception of the cost of the medication. If your insurance does not pay, you will be responsible for any outstanding balance.

6. I understand that medication is ordered on a per patient basis and that I am to pay in advance the amount listed below for the full month of injections. At any point I can choose to discontinue the program. Cash price of each visit is also listed below to make you aware of what you would be responsible for if your insurance does not pay for these services.

Price	To include
Medication Vial $250	5mg/mL, 2mL vial (month supply)
$80.40	Office visit (weight loss consult with provider)
4 Nurse Visits $160	Nurse visit (once a week injection)



PREMIER MOUNTAIN
ADULT MEDICINE

7. I acknowledge that all statements provided on the Medical History Forms are true and accurate to the best of my knowledge and that my treatments will be based on the information provided herein and if I willingly withhold information, I accept full liability for any consequence that may arise therefrom.

8. I acknowledge that Semaglutide is in high demand throughout the country and is not an FDA approved, and it is possible that the medication may not be available at a future date.

8. SEMAGLUTIDE CONTRAINDICATIONS: I UNDERSTAND THAT IF I HAVE ANY OF THE FOLLOWING I SHOULD NOT TAKE SEMAGLUTIDE INJECTIONS: diabetic retinopathy (a type of damage to the eye from diabetes), low blood sugar, decreased kidney function, pancreatitis, medullary thyroid cancer, multiple endocrine neoplasia type 2, family history of medullary thyroid carcinoma and/or kidney disease with likely reduction in kidney function.

9. I have read and understand all the above statements and conditions and have been informed and given a copy of potential side effects and risks that may be associated with the use of Semaglutide. I fully understand what I am signing and hereby request and consent to this weight-loss treatment.

Patient Signature: ________________________________

Date: _______________

Provider Signature: ______________________________

Provider name: _________________________________

Date: _______________