1055 Ruth St., Suite #1
Prescott, AZ 86301

CHERI LEDSOME FNP-C, PMHNP-BC

MOUNTAIN VIEW
MENTAL HEALTH AND PRIMARY CARE

Please complete form in its entirety

Patient Information

Patient Information:

Last Name:	First Name:	M.I.:	Date of Birth:

Mailing Address: Apt #

City/State/Zip:

Home Phone:	Cell Phone:	Work Phone:

Email Address: Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Sex: ☐ Male ☐ Female ☐ Transgender ___ do not wish to disclose

Social Security #:

Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____

Employer Name:

Emergency Contact Name and Phone:

Relationship to Patient:

Additional Information and Responsible Party

Responsible Party- If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor:

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:	Relationship to Patient:

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Race (please select):

☐ White ☐ American Indian or Alaska Native ☐ Asian
☐ Hispanic ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Other ☐ Decline

Ethnicity (please select one):

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Sign Language ☐ Spanish ☐ Russian

Preferred Pharmacy Name & Location:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Member ID & Group #:	Member ID & Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

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Health Information Release Form

Please print all the information requested, then sign and date the form at the bottom of the page.

Patient Name:_____ **DOB**:_____

The following person(s) have permission for any disclosure of my personal health information and authorization to pick up any medical records pertaining to my health care.

Authorized Person Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Expiration or Termination of Authorization: This authorization will remain in effect until terminated by you, your personal representative, or another individual(s) of legal entity authorized to do so by court order or law
- Right to Revoke or Terminate: You have the right to revoke or terminate this authorization by submitting a written request at any time. This can be done in person or by mailing in a request to your office location.

Disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

By signing below, I am indicating I have read the above information and fully acknowledge and understand the risk to my protected health information.

Patient Signature:_____ **Date**:_____

Witness Name/Title:_____

Witness Signature:_____ **Date**:_____

MOUNTAIN VIEW
MENTAL HEALTH AND PRIMARY CARE

MEDICAL RECORDS RELEASE

PATIENT NAME:_____ **DOB**:_____**PHONE**:_____

ADDRESS: _____

_____

Description of information to be disclosed – I authorize the practice to disclose the following protected health information to the entity person, or persons identified below.

TREATMENT DATE(S): _____

___ Entire patient record _ Office visits _Lab results _Imaging results

___Immunizations ___Ledger _ Itemized receipt ___Other:_____

Purpose of Disclosure:

___ Patient Request _ Specialist _ New PCP ___Insurance/FSA _ Taxes

___ Other: _____

Record Retrieval:

___ Mail copies to the address provided _ Fax records to the following:_____

___ I am planning to pick the copies up, please notify me when ready (can take up to 30 days)

(FROM) The following organization is authorized to make the discloser:

Individual/Entity Name:_____

Address:_____

Phone:_____Fax:_____Email:_____

**I authorize the entity identified above to disclose or provide protected health information about me to the individual/entity listed below.

(TO) Who will be authorized to receive information:

Individual/Entity Name:_____

Address:_____

Phone:_____Fax:_____Email:_____

**Note: Some fax and email transmission methods are not secure and it is possible for your PHI to be compromised during transmission from out practice. Do not designate fax or email as your preferred method if this is a concern to you. This authorization will expire after 12 months unless otherwise specified by you. You have the right to terminate this authorization at any time by submitting a written request. Termination will be effective upon received written notice. We have no control over the person(s) you have listed to receive your PHI. Therefore, your PHI disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice. A fee may apply.

Patient/Authorized Representative Name:_____**Relationship:**_____

Patient/Authorized Representative Signature:_____**Date:**_____