First:	Middle:	Last:

PHYSICAL Address:
MAILING Address:
EMAIL to sign up for Patient Portal:

Home Phone:	Cell Phone:	Work Phone:

DOB:	Sex: ◻ Male ◻Female	SSN:	Marital Status: (M) (W) (S) (D)

Ethnicity (please select one):	Race:	Language (please select one):
○ Hispanic or Latino ○ Not Hispanic or Latino ○ Decline	○ ____________ ○ Refused/Other	○ English ○ Other ____________

Preferred Pharmacy Name & Location:

Emergency Contact & Hipaa

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize Mountain State Health & Wellness and staff to release any and all information regarding my Protected Health Information (PHI), conditions and treatments to the following person(s):

Name:	Name:
Address:	Address:
Phone:	Phone:
Relationship to Patient:	Relationship to Patient:

Primary Medical Insurance:	**Secondary Medical Insurance:**
Ins. Co. Name	Ins. Co. Name
Policy Holder Name:	Policy Holder Name:
Policy Holder's DOB:	Policy Holder's DOB:
Policy Holder's ID #:	Policy Holder's ID#:
Patient Relationship to Policy holder:	Patient Relationship to Policy holder:

Have you designated a Durable Medical Power of Attorney for Health Care? ◻ YES ◻ No

If no, would you be interested in POA information at today's visit? ◻ YES ◻ No

Signature: ______________________________________ **Date:** ________________

*This will remain on file as valid until you complete, sign and date a new form.

FULL NAME: ________________________________ DATE: __________________

BIRTHDATE: ______________________

ALLERGIES _____**NO ALLERGIES**

ALLERGY	ALLERGIC REACTION

MEDICATIONS _____**NO MEDICATIONS**

MEDICATIONS (LIST ALL)	DOSE (mg, pill, etc)	TIMES PER DAY

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	DATE:	DR:	ABNORMAL Y N
COLONOSCOPY	DATE:	DR:	ABNORMAL Y N
MAMMOGRAM	DATE:	DR:	ABNORMAL Y N
PAP SMEAR	DATE:	DR:	ABNORMAL Y N
BONE DENSITY(DEXA)	DATE:	DR:	ABNORMAL Y N

VACCINATION HISTORY

TETANUS/TDAP	FLU	SHINGLES	PNEUMOVAX	PREVNAR
DATE:	DATE:	DATE:	DATE:	DATE:

WOMENS HEALTH HISTORY

DATE OF LAST MENSTRUAL CYCLE	1ST MENSTRUATION AGE__MENOPAUSE AGE___
# OF PREGNANCIES:	# OF LIVE BIRTHS:
PREGNANCY COMPLICATONS:	

PATIENT NAME: ______________________________

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
ALCOHOLISM/DRUG ABUSE			
ASTHMA			
CANCER (TYPE: ____________)			
DEPRESSION/ANXIETY/BIPOLAR/SUICIDAL			
DIABETES (TYPE: _________)			
EMPHYSEMA(COPD)			
HEART DISEASE			
HIGH BLOOD PRESSURE (HYPERTENSION)			
HIGH CHOLESTEROL			
HYPOTHYROIDISM/THYROID DISEASE			
RENAL(KIDNEY) DISEASE			
MIGRAINE HEADACHES			
STROKE			
OTHER			
OTHER			

SURGERIES

TYPE (SPECIFY LEFT/RIGHT)	DATE	LOCATION/DR/FACILITY

SOCIAL HISTORY

OCCUPATION (OR PRIOR OCCUPATION)	EMPLOYER:
NIGHT SHIFT? Y N N/A	__RETIRED __UNEMPLOYED ___LOA ___DISABLED
YEARS OF EDUCATION	HIGHEST DEGREE
MARITAL STATUS __SINGLE __PARTNER __MARRIED __DIVORCED __WIDOWED __OTHER	
DO YOU HAVE CHILDREN Y N	IF YES, HOW MANY?

HAVE YOU TRAVELED OUTSIDE OF THE COUNTRY IN THE LAST 30 DAYS? Y N	IF YES, WHERE?
HAVE YOU SERVED IN THE MILITARY? Y N	HOW LONG_____BRANCH__________
WERE YOU DEPLOYED? Y N	IF YES, WHERE? ________________

PATIENT NAME: ______________________________

CHECK ALL THAT APPLY	ALCOHOL/DRUG ABUSE	ASTHMA	CANCER (TYPE____)	EMPHYSEMA (COPD)	DEPRESSION/ANXIETY	BIPOLAR/SUICIDAL	DIABETES	EARLY DEATH	HEART DISEASE	HIGH CHOLESTEROL	HIGH BLOOD PRESSURE	KIDNEY DISEASE	STROKE	THYROID DISEASE	MIGRAINES	OTHER	OTHER	OTHER
MOTHER																		
FATHER																		
BROTHER																		
SISTER																		
CHILD																		
GRANDMOTHER																		
GRANDFATHER																		

OTHER HEALTH ISSUES

TOBACCO USE	SMOKE CIGARETTES? Y N
CURRENT PACKS/DAY ___# OF YEARS ___	PAST: QUIT DATE: ___PACKS/DAY___ # OF YEARS ____
OTHER TOBACCO (CHECK ONE) ___ PIPE _____CIGAR ______SNUFF ___CHEW	

ALCOHOL/DRUG USE	DO YOU DRINK ALCOHOL? Y N	___BEER ___WINE __LIQUOR	# PER WEEK: _____
Marijuana or recreational drugs? Y N		Ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

SEXUAL ACTIVITY		Sexually involved currently? Y N
Sexual partner(s) is/are/have been: ___Male___Female		
Birth control method? __None__Condom__Pill/ring/patch/depo/iud__Vasectomy		
EXERCISE		Do you exercise regularly? Y N
What kind of exercise?		How long(MIN): _____ How often: ________
SLEEP		How many hours, on average, per night? ____
DIET	____Good___Fair____Poor	Would you like advice on your diet? Y N
SAFETY	Bike helmet? Y N	Wear seat belts consistently? Y n
Working smoke detector in home? Y N		If guns are in your home...locked up? Y N
Is violence at home a concern for you? Y N		

PATIENT NAME: ______________________

	CONSTITUTION		CARDIOVASCULAR		SKIN
	Activity change		Chest pain		Color change
	Appetite change		Leg swelling		Pallor
	Chills		Palpitations		Rash
	Diaphoresis		**GASTROINTESTINAL**		Wound
	Fatigue		Abdominal distention		**ALLERGY/IMMUNO**
	Fever		Abdominal pain		Environmental allergies
	Unexpected weight change		Anal bleeding		Food allergies
	HEAD, EAR, NOSE & THROAT		Blood in stool		Immunocompromised
	Congestion		Constipation		**NEUROLOGICAL**
	Dental problem		Diarrhea		Dizziness
	Drooling		Nausea		Facial asymmetry
	Ear discharge		Rectal pain		Headaches
	Ear pain		Vomiting		Light-headedness
	Facial swelling		**ENDOCRINE**		Numbness
	Hearing loss		Cold intolerance		Seizures
	Mouth sores		Heat intolerance		Speech difficulty
	Nosebleeds		Polydipsia		Syncope
	Postnatal drip		Polyphagia		Tremors
	Rhinorrhea		Polyuria		Weakness
	Sinus pressure		**GENITOURINARY**		**HEMATOLOGIC**
	Sneezing		Difficulty urinating		Adenopathy
	Sore throat		Dysuria		Bruises/bleeds easily
	Tinnitus		Enuresis		**PSYCHIATRIC**
	Trouble swallowing		Flank pain		Agitation
	Voice change		Frequency		Behavior problem
	EYES		Genital sore		Confusion
	Eye discharge		Hematuria		Decreased concentration
	Eye itching		Penile discharge		Dysphoric mood
	Eye pain		Scrotal swelling		Hallucinations
	Eye redness		Testicular pain		Hyperactive
	Photophobia		Urgency		Nervous/anxious
	Visual disturbance		Urine decreased		Self-injury
	RESPIRATORY		**MUSCULAR**		Sleep disturbance
	Apnea		Arthralgias		Suicidal ideas
	Chest tightness		Back pain		
	Choking		Gait problems		
	Cough		Joint swelling		
	Shortness of breath		Myalgias		
	Stridor		Neck pain		
	Wheezing		Neck stiffness		

MOUNTAIN STATE HEALTH & WELLNESS

GHALI BACHA, MD

JESSICA UEDA, NP

AUTHORIZATION FOR REALEASE OF PROTECTED HEALTH INFORMATION TO MSHW

Patient Name ______________________________

DOB ______________

Address ______________________________

____

Phone ________________

You must initial each line of request!

I hereby request and authorize ________________________________ to release the following to Mountain State Health & Wellness:

_______ A copy of my complete medical record **including** substance abuse records, mental health records, HIV and STD records

_______ A copy of my complete medical record **excluding** substance abuse records, mental health records, HIV and STD records

_______ A copy of medical records for:

- ____ Emergency Room care I received on ___________
- ____ Outpatient care I received on ___________
- ____ Hospitalization I had on __________
- ____ X-Rays I had taken on _________
- ____Lab tests I had on _________
- ____ Other ____

I am requesting that my health information be released for the following reason

- ____ Transfer of Care
- ____ Other ____

MY RIGHT TO REVOKE: I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION. I ALSO UNDERSTAND THAT I SHOULD REFEREE TO THE NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION ON HOW I REVOKE AN EXCEPTION TO ANY RENOVATION. I UNDERSTAND MOUNTAIN STATE HEALTH & WELLNESS MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS ON MY SIGNATURE OF THIS AUTHORIZATION. I ALSO RELEASE MOUNTAIN STATE HEALTH & WELLNESS AND ITS EMPLOYEES FROM ANY RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE RELEASE OR REPRODUCTION OF THESE HEALTH RECORDS.

________________________________ ________________

Signature of Patient or legal guardian Date
(Court order for legal guardianship required)

310 35TH STREET, SE, SUITE 11 • CHARLESTON, WV 25304 • PHONE: 304.720.9595 • FAX: 304.720.9596

Mountain State Health & Wellness

Ghali Bacha, MD **Jessica Ueda, AGPCNP-BC**

NAME______________________________________DOB____________________

Thank you for choosing us as your primary care provider we are committed to providing you with quality and affordable healthcare. We ask all patients to review and sign this policy. A copy can be provided upon request.

1. **Insurance:** We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility, please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.
2. **Patient payment:** ALL copayments and deductibles are to be paid at the time of service. This arrangement is part of your Contract with your insurance.
3. **Forms:** There is a $30.00 fee (2 pages or more) for completing FMLA, sick leave, AFLAC, and disability insurance forms, etc. $10.00 for one page. This fee must be paid before the forms are completed.
4. **Registration:** All patients must complete our patient information forms, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us within 30days, you will be responsible for the balance.
5. **Claims:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not a party to that contract.
6. **Uninsured patients:** Payment is due at the time of service.
7. **Credit and Collection:** If your account is more than 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If you have a past due balance, it is the policy of this office to discharge the patient and possible immediate family members from the practice. You will at that time be notified by regular and certified mail that you will have 30 days to find alternative medical care. During that 30-day period our practitioners will see you on an emergency basis only such as a hospital follow up with payment in full for visit.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

SIGN____ DATE____________________

MOUNTAIN STATE HEALTH & WELLNESS

GHALI BACHA, MD | JESSICA UEDA, C-FNP

POLICY STATEMENT
RE: CHRONIC PAIN & PSYCHOTROPIC MEDICATIONS

Mountain State Health & Wellness and its providers care for patients that require general adult internal medicine evaluation and treatment. As such, treating chronic pain syndromes and psychiatric aliments are not within the general scope of this practice. It may be considered only in situations where the patients already maintain clinical follow-ups and primary care management for the above processes by a specialist in the respective fields. The practice will continue to offer care and medical management to such patients who otherwise have another provider who will address the patient's chronic pain and psychiatric needs.

Temporary and short term treatments for pain and psychiatric diseases may be considered only in certain cases, while the patient seeks permanent caregivers for the above; this is solely at the discretion of the provider. This policy does not necessarily affect patients suffering from cancer related pain. Any patient that may receive narcotic pain medications at this practice automatically accepts being monitored for proper usage and will render the patient delinquent and subject to termination of any patient-provider relationship at this practice and open to further investigation that may come under the jurisdiction of the state and federal laws and regulations, including medical and pharmaceutical boards.

____________________________ ____________________________

Patient Name (Print) Patient Signature

____

Date

Mountain State Health & Wellness

Ghali Bacha, MD **Jessica Ueda, AGPCNP-BC**

We would like to take this opportunity to welcome you to our practice and to thank you for choosing our physicians to participate in your healthcare. We look forward to providing you with personalized, comprehensive health care focusing on wellness and prevention. As continuity and coordination of patient care is essential in meeting your healthcare needs, our physicians, nurse practitioner, medical assistants, and office staff work closely in a "team approach" to support your patient care.

Our office is open Monday through Friday from 8:00am-4:00pm. Every effort is made to see our patients for medical problems during these hours. Please note that our schedulers are available every day and will do their best to accommodate you. Booking an appointment is essential to ensuring all patients receive the time they require for quality medical care. We have an answering service for emergency after hours, who can be reached by calling our office directly.

Before you visit, please notify your health insurance company of your new primary care provider if required. We also request that you contact your previous physician and specialists and request that a copy of your medical record be sent to us. A release is enclosed.

Please fill out the enclosed forms and mail them **before** your appointment or email them to us at **manager@medwv.com**. We **must** receive your paperwork **before** your appointment, or you may be rescheduled. During your initial visit, we will be reviewing your health status and these forms contain information necessary to complete this process. Please bring your **health insurance identification card as well as a photo I.D.** Please bring a **complete list of all your medications**, as well as the strength and dose of each one (bring your rx bottles).

Once again, we would like to thank you for choosing us as your primary health care provider. We look forward to working with you.

Sincerely,

The Providers and Staff of Mountain State Health & Wellness