# High Mountain Healthcare, LLC

Pediatric New patient request (updated 11/12/25)

Which provider do you wish to see:_____

By becoming a patient of High Mountain Healthcare, you acknowledge and agree by signing below that yearly appointments (Medicare Wellness, Well Child Checks and Adult Annual Wellness) are required and are not optional.

Please complete the attached new patient packet and bring it back to our office, **being sure to include a copy of the front AND back of your insurance card(s).**

If you will be self-pay, please write "self-pay" on the insurance line of the Patient Information Sheet and sign the Self Pay Form.

Self-pay fees are as follows and will be collected on date of service:

New patients/Wellness visits - $125.00-$200.00

Follow up/Sick visits - $75.00-$125.00

Patient name_____DOB_____

Signature of patient or guardian_____Date_____

P.O. Box 2239 • Blairsville, GA 30514
63 Pleasant Hill Road • Blairsville, GA 30512
706-745-2229 • Fax: 706-745-0836

Welcome to High Mountain Healthcare, LLC. We are honored that you have chosen us as your health care provider. Our goal is to provide you with the highest quality of healthcare possible through excellent service, personal attention, and the very best in medical treatment. We do not only want to meet your immediate medical needs, but also to educate you in proper health maintenance and illness prevention in order to assure optimal wellness throughout your life. Thank you for placing your trust in us.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following information is required:

## Please initial that each of these things is completed prior to dropping off paperwork.

_____Patient Information Form
_____Patient Health Assessment, Lead, TB screening, EPDS, and Breastfeeding screening
_____Preferred Contacts Form
_____Consent to Treat
_____Health Assessment Form –***must be completed entirely***
_____Full medication list (including OTC and herbal supplements)
_____**Insurance/Payment Method (please attach a copy of the front and back of your insurance cards**

____I have verified that my insurance is in network with Privia Medical Group of Georgia.

**If anything is not completed, you will be asked to come back and pick up the paperwork or bring required materials to us before we are able to proceed with your request.**

As a high volume practice, we have the right to accept or deny new patient requests due to the complexity of care. Failure to comply with our policies and procedures may result in denial or dismissal.

**Our office does not offer chronic pain management.**

Please review our policy and procedures as a reference pertaining to our office practices. The next 3 pages in this packet are yours to keep for reference of our policies. **Please keep these pages, do not return with the packet.**

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the explained policy and procedures.

_____ _____

Patient name (printed) and Date of birth Signature of parent/guardian

# *Welcome to High Mountain Healthcare*

Our mission is to provide you and your family with the highest quality healthcare experience possible through excellent service, personal attention, and the very best in medical treatment. Focusing on the entire family, from children to seniors, is our priority and one that demands that we know and respect each patient as if they were a member of our own family. Our goal is not only to meet our patient's immediate medical needs, but to educate them in proper health maintenance and illness prevention in order to assure optimal wellness throughout their lives. Your healthcare is our business. Thank you for placing your trust in us.

In order to provide you with the best care possible, we have established the following policies:

1. **Sick Visits-** We leave time open every day to see our patients who are acutely ill. Please call us as soon as possible to schedule your sick visit, as these appointments are limited. If we are not yet open, please leave a message on the appointment line voicemail, and we will call you back as soon as possible. We will do everything possible to see you that day-especially if you call early. Please know, though, that because you may have to be "worked in" between scheduled patients, there may be a wait. If we are able to give you an exact appointment time, please be on time. We may ask you to reschedule if you arrive late. If you become ill over the weekend when our office is closed or cannot wait for an appointment, please go to your nearest walk-in clinic or Union General Hospital Emergency Room. **We are not a walk-in facility. If you walk in we will give you the next available appointment spot if we have one available that day.**
2. **Regular Appointments-** We have regular scheduled appointments for our patients to give you the full attention you deserve. If you arrive late, then we run behind, inconveniencing other patients with later appointments. We ask all established patients to arrive at least 15 minutes prior to their appointment. If you arrive late you may be asked to reschedule. In respect for your time, we will always attempt to stay on schedule as much as possible and will let you know if we are running behind. **Please be sure to check-out after every appointment.**
3. At each visit you will be asked to verify your information is up to date. Once a year we will have you complete an annual update and get copies of your insurance cards. It is your responsibility to let us know if you have any changes during the year. Please assist us in maintaining your most accurate patient information by contacting us with any changes that you might have to your name, address, insurance, or phone numbers. Changes can also be made on our web portal if you are signed up for it. We will collect any copays, self pay payments, missed appointment fees, and balances when you check-in prior to your appointment.
4. **Missed Appointments-** We will attempt to contact you prior to your appointment with a reminder call, however, this is a courtesy call and should not be relied on to remind you of your appointment. Please keep the appointment card you will be given at check out or write the information down on your calendar so that you are aware of your upcoming appointments. **You are ultimately responsible for remembering your appointment.** If you will be unable to keep a scheduled appointment, please give us at least a 24 hours notice so that we can give that time slot to another patient who needs to be seen. Failure to give at least a 24 hours notice of a appointment cancelation could result in a $25 fee. If you and/or your family members together miss three (3) appointments in one year without calling beforehand to let us know, you and/or your family members may be dismissed from the practice. Please make sure that your contact numbers are kept up to date so that we can contact you to help keep you aware of your appointments.

5. **Lab and Test Results-** We will inform you as soon as possible of your lab and test results. It usually takes us several days to get your bloodwork results back. For this reason, please allow three (3) business days for processing before contacting us for results. Usually, if your bloodwork is normal, High Mountain Healthcare will mail you a letter with a copy of your results as soon as they get them. However if you are coming in soon for an appt, your labs will not be mailed, but a copy will be provided for you when you come in. If your bloodwork is abnormal, we will attempt to contact you by phone as soon as possible. X-rays and other tests may take us up to a week to get the results back. However, we will get you the results as quickly as possible. Some patients like to have their blood drawn one week prior to their visits so the results are available for discussion at the time of their appointment. We have a lab in our office where you can have your blood drawn. You will need to schedule a day to come in for labs as we only schedule so many labs per day. We cannot draw any labs without an order from the doctor.
6. **Regular Health Exams-** We believe in preventing illness, not just treating it. Therefore, we encourage all our patients to have regular "check-ups." We perform wellness exams, including pap smears, physicals, and well child checks. We give all regular pediatric vaccines. An in-house lab provides the convenience of having blood work drawn on site and we schedule appointments for labs. We recommend to be seen once a year to keep up to date. **Once you have not been seen in 3 years you will be considered inactive in our system.**
7. **Refill Requests-** The medications we prescribe are an important part of your treatment. Please check all of your medications before each visit to see if you need refills. If you have received medications from other physicians, please bring your bottles with you so we can update your records. If you find you are running low on a medication and will run out prior to your next visit, please call our office and leave the following information on the appropriate medical assistant's line for your physician:

   Patient Name and Date of Birth, Name of Medication and Dose, How Often You Take It, and Pharmacy Name

   ***We will make every effort to refill the medication the day that you call, but request that you give us at least 48-72 hours notice***. Please do NOT wait until you are out of your medication before you call. Controlled substance prescriptions cannot be called in and must be picked up in person. Due to increased demands and health care changes, there will be a charge of $25 to process Prior Authorizations for anyone over the age of 18. This process is extremely time consuming for our staff. New governmental changes and guidelines are making this request more and more common. If you desire for our office to accomplish this task for you, then the $25 must be paid before it will be completed. Completing this paper work, in no way guarantees that the medication requested will be approved by your insurer.
8. **Records Request**- If you need a copy of your medical records, we require 3-5 business days to assemble and make ready the records for delivery. We do charge a fee to process a records request. The fee is based on the total number of pages contained in the records and there is not a fee to transfer records to another physician.
9. **Form Completion**- In the event that a patient requires us to complete paperwork for an outside source, and depending on the complexity and time involved, a service charge may be assessed. Short forms requiring minimal time to complete will be assessed a $10 fee. Complex forms requiring 15 or more minutes to complete, and which do not require an office visit, will be assessed a $35 fee. Some form completion work requires an office visit with your physician. In this case, a standard office visit charge will apply. Some forms will take longer for completion. ***Please allow up to 5 business days for completion.***

**Additional policies and procedures:**

**When contacting the office:** Please do not leave multiple messages on the lines. We will return your call in a timely manner. If you leave multiple messages, this will only increase the wait time for your return call. Please be aware that we cannot possibly answer every phone call that comes into the office, if you do get a recording please leave a message including the patients name, date of birth, and a phone number to return your call and we will return your call as soon as possible. If it is urgent and you can't wait for a return call please go to an emergency room or walk-in near you. **Please do not contact our staff or medical providers by text or social media for appointments or any medical advice as this is a liability.**

Every patients time is important to us. When you come in for any type of service (appointment, shot, pick up rx, etc.) we help patients in the order they arrive. Therefore, we ask that whenever you come into the office you sign in and put the reason you are here so we can better serve everyone in a timely manner. Medical Assistants cannot be pulled from the back if you walk-in and need to talk to them. Please call the office and leave a message for the MA, they will return your call as soon as they get a chance. They try to return calls around lunch and again before they go home. Again, when you call in, you will have to leave message. They are with patients throughout the day and cannot be interrupted. If you need a prescription please leave a message on the MA's line as well.

**Patients in Waiting Rooms and Exam Rooms**: Parents and guardians must watch their children in the waiting room. Please do not allow little ones to run or climb on the furniture. Children cannot be left alone in the waiting area or exam rooms without an adult. Toys are provided in waiting area for our patients, however please put them back after you are done so no one will trip over them. Children must be kept off the rolling stool in the exam rooms. Please do not allow your children to touch our medical equipment or supplies. You are held liable for the safety of your children.

***We have Physicians Assistants and Nurse Practitioners which can treat patients independently, but are always under the supervision of Dr Bradford. Dr Bradford has a full patient load and there will be many times when you will be asked, especially for same day sick, to see one of the other providers. Dr. Bradford has the utmost confidence in them to treat and care for the needs of her patients.***

As a patient of High Mountain Healthcare you will see the provider that is available to help meet your healthcare needs. Please be aware you may not always see the same provider every time that you come in. If you only want to see a doctor, we understand, however our practice will not be able to meet those needs and we would recommend you find another practice that will better suit you.

Again, we thank you for trusting High Mountain Healthcare, we look forward to serving your healthcare needs.

Sincerely,

The Staff of High Mountain Healthcare

*High Mountain Healthcare, LLC - Newborns*

## Pediatric Information Sheet

**Patient's** Last Name_____First_____Middle Initial____

Mailing Address_____ City/State/Zip_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

Race_____Ethnicity_____Preferred Language_____

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**Mother's** Name_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (___)_____Wk Phone (___)_____ Cell Phone (___)_____

Contact preference: HOME CELL WORK PORTAL MAIL May we text you? YES NO

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____ ( ) I do not have an email Marital Status: M S D W

**Father's** Name_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (___)_____Wk Phone (___)_____ Cell Phone (___)_____

Contact preference: HOME CELL WORK PORTAL MAIL May we text you? YES NO

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____ ( ) I do not have an email. Marital Status: M S D W

***If not in parents care:***

Guardian Name_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (___)_____Wk Phone (___)_____ Cell Phone (___)_____

Contact preference: HOME CELL WORK PORTAL MAIL May we text you? YES NO

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____( )I do not have an email. Marital Status: M S D W

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**EMERGENCY CONTACT:**

Name_____ Relationship to patient_____

Hm Phone_____Wk Phone_____Cell Phone_____

**Insurance Information (please put name and ID number or attach copy of insurance cards)**

Primary Insurance Company Name_____

Secondary Insurance Company Name_____

Third Insurance Company Name_____

**IF INSURANCE HOLDER IS DIFFERENT FROM PATIENT:**

Name_____ Relation to patient_____

Mailing address (if different from patient)_____City/State/Zip_____

Hm. Phone (____)_____Wk Phone (____)_____ Cell Phone (____)_____

Birthdate_____ Soc. Sec.Number_____ Male_____ Female_____

E-mail_____Marital Status: M S D W Employed by:_____

Employers Address_____City/State/ Zip_____

I certify that the above information is correct. I understand the office financial policies and procedures. I understand that High Mountain Healthcare reserves the right to add 10% collection fee and any additional attorney fees that may apply to my account if it is forwarded to a collection agency.

Signature of patient or guardian_____

# High Mountain Healthcare, LLC

**Self-Pay Patient Agreement (effective 7/13/21)**

Due to a new management company we have had to make some changes to our self pay rates and process:

_____ (Initial) We will collect the minimum for your appointment type at check in. New or Wellness visits will be $125 and follow up or sick visits will be $91.50.

_____ (Initial) This is the minimum fee for your appointment and based on services could be more. In the case that there are additional charges you will be sent a bill.

_____(Initial) Self pay labs will be calculated and collected prior to your lab draw. Any additional lab fees from the lab will be billed to you.

**All self pay fees are due at time of service**

I have read and understand that I am responsible for all services rendered to me by High Mountain Healthcare. I am aware that the minimum for self-pay fees are due at the time of service.

_____

Patient Name

_____

Signature of Patient or Guardian

_____

Date

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63 Pleasant Hill Road • Blairsville, GA 30512
706-745-2229 • Fax: 706-745-0836

# High Mountain Healthcare, LLC

Preferred Communication Agreement

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. Please tell us your preferred place and manner of communication. **You may update or change this information at any time; please do so in writing.**

Patient Name_____ Date of Birth_____

Parent/Guardian Name_____

I prefer to be contacted in the following manner (**check ALL that apply and provide information requested**)

_____Patient Portal - email_____

_____Home Telephone – phone number_____

_____Cell Phone – phone number_____

_____Work Phone – phone number_____

_____Written Communication – send to home address on file

We respect your right to tell us who you want involved in your/your child's treatment. Our secure patient portal is our primary means of patient communication, such as sharing your test results. You can control access to your/your child's patient portal.

**Please indicate the person(s) with whom you prefer we give access to the patient portal below. Also, list anyone, other than patient/guardian listed above, able to be in an office visit or pick up information on the patient/child. Please update this information, in writing, if your preferences change.**

1). Name_____Phone _____

Email_____ Relationship_____

2). Name_____Phone _____

Email_____ Relationship_____

3). Name_____Phone _____

Email_____Relationship_____

**Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information and scheduling appointments.**

We, generally, do not share your information via email. We ask that you give another individual access to your secure patient portal if you wish for us to share information with them. You can set this up yourself through the portal or contact 1-888-774-8426- Monday – Friday 8am- 6pm ET.

**ACKNOWLEDGMENT:** I understand that HIPAA may permit my provider to share my information with other persons **not** named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient/Parent signature_____Date_____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

P.O. Box 2239 • Blairsville, GA 30514
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High Mountain Healthcare | PRIVIA MEDICAL GROUP

## Authorization and Consent to Treatment

***Assignment of Benefits and Authorization to Release Medical Information.*** I hereby certify that the insurance information I have provided is accurate, complete, and current, and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider. I authorize my provider, or any holder of medical information about me or the patient named below, to release to my health insurance plan such information needed to determine the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

***Guarantee of Payment & Pre-Certification.*** In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

***Consent to Treatment.*** I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary; however, I may refuse any treatment or procedure at any time.

***Consent for Telehealth Services.*** If I request or initiate a telehealth visit (a "virtual visit"), I acknowledge that I have reviewed the Informed Consent for Telehealth Services.

My consent shall cover medical examinations, procedures and testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (such as stitches), cast application/removals, and vaccine administration. My consent shall also cover treatment by care center staff acting under my provider's supervision and direction. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain. My consent shall also cover the use of photography and internal recording devices for the purpose of scribing and clinical documentation improvement. All internal recording adheres strictly to Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected.

***Consent to Call, Email & Text.*** I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff, by visiting "My Profile" on my myPrivia Patient Portal, or by emailing the Privacy Officer at privacy@priviahealth.com.

***HIPAA.*** I understand that my provider's Privacy Notice is available on my provider's website and at priviahealth.com/hipaa-privacy-notice/ and that I may request a paper copy at my provider's reception desk.

***I hereby acknowledge that I have received my provider's Financial Policy, the Informed Consent for Telehealth Services (if applicable), as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy and the Informed Consent for Telehealth Services. I also agree to the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Privia Health affiliated providers.***

**Printed Name of Patient:** | **Email:** _____

**Signature:** _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

**Name and Relationship of Person Signing, if not Patient:** _____

***Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the my provider HIE Opt-Out Request Form and/or contact the HIE directly.**

High Mountain Healthcare | PRIVIA MEDICAL GROUP

**Informed Consent for Telehealth Services**

I, the undersigned patient (or personal representative), acknowledge that I have read and fully understand this consent form. I agree to receive healthcare services from the provider listed below via telehealth.

**Permitted Activities**

I understand and consent to the use of telehealth services for the following activities, as determined to be appropriate by my practitioner:

- Diagnosis, evaluation, and treatment of my condition.
- Prescription refills.
- Appointment scheduling and management.
- Patient education and counseling.
- Consultation with other healthcare providers.
- Remote patient monitoring.

**Practitioner's Role and Determination**

I understand and agree that it is the role of the practitioner to determine whether or not my condition is appropriate for a telehealth encounter. I acknowledge that my practitioner may, at any time, determine that an in-person visit is necessary and may discontinue telehealth services.

**Privacy, Security, and Risks**

I understand that the laws protecting the privacy and confidentiality of my medical information apply to telehealth services. I have been informed of the following security measures to protect my information, as well as the potential risks to my privacy:

- **Security Measures:** All patient information transmitted during or in relation to telemedicine services is protected through transport-level encryption, such as Transport Layer Security (TLS) for email and HTTPS for web-based communications. Data on all workstations is encrypted at rest using whole disk encryption to render it unusable and unreadable to unauthorized individuals. These technical safeguards are part of a comprehensive security program designed to protect electronic Protected Health Information (ePHI) including the use of unique user IDs for system access, requiring multi-factor authentication, and conducting regular security risk assessments.
- **Potential Risks:** I acknowledge that despite these security measures, there are potential risks to my privacy, including but not limited to, the possibility of technical failures, data breaches, or unauthorized access during the telehealth session.

**Hold Harmless Clause**

I agree to hold my provider and their staff harmless for any information lost due to technical failures, including but not limited to, interruptions in video or audio connections, internet outages, or hardware malfunctions.

**Third-Party Information Sharing**

I understand that my patient-identifiable information will not be forwarded to a third party for any reason without my express, written consent, unless permitted under applicable law.

**Patient Rights**

I understand that I have the right to withhold or withdraw my consent to the use of telehealth services at any time, without affecting my right to future care or treatment. I also understand that I have the right to access my medical information and copies of my medical records.

**Printed Name of Patient:**

**Signature:** _____ **Date:** _____

To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent.

# High Mountain Healthcare, LLC

## Pediatric New Patient Health Assessment

*The information you provide is CONFIDENTAL. It is to evaluate your health profile and risk factors. Please complete all sections.*

**Date**_____

**Name**_____ **Date of Birth**_____

**Parent/Guardian Name:** _____

**Who has primary custody of the patient?** _____

**Is your child in daycare, school, or with a babysitter?** _____

**Emergency Contact**
**Name**_____ **Phone**_____

**Present Illness:** Please list the health problems which concern you or which you are being treated for.

| | |
|---|---|
| | |
| | |
| | |

**Allergies:** Please list any allergies to medications. Include foods and environmental allergies.

| | |
|---|---|
| | |
| | |
| | |

**Medications:** Please list all medications with dosage and the number of times per day. Include all over-the-counter medications and supplements.

| | |
|---|---|
| | |
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| | |
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| | |
| | |

Which pharmacy is used:_____
Does the child prefer medications to be liquid or pill form?_____

Is your child up to date on immunizations? No___ Yes___

**Surgical History:** Please include any/all surgeries

| | |
|---|---|
| | |
| | |
| | |
| | |

**Past Medical History:** List all hospitalizations and serious medical problems that they have had such as RSV, pneumonia, fevers, etc.

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Birth History:**

| | |
|---|---|
| Delivery Method (Circle One)<br>Vaginal Caesarean Section | Birth Weight:_____<br>Hospital Discharge Weight:_____ |
| Full Term No___ Yes___<br>If not, Birthed at_____weeks | Birth Problems/Complications: |
| Was baby circumcised? No___ Yes___<br>If so, When?_____ | Hospital/Facility of birth: |
| Newborn Screening Results: | Hearing Screening Results:<br>Cardiac Screening Results: |

**Family History:** Please designate which family member had the following illnesses

| | | | |
|---|---|---|---|
| Alcoholism | Hypertension | Diabetes | COPD |
| Attention Deficit | Heart Attack | Thyroid Disorder | Asthma |
| Bipolar Disorder | Heart Disease | Dementia | Osteoporosis |
| Depression | Stroke | Blood Clots (DVT) | Rheumatoid Arthritis |
| Cancer (Breast) | Cancer (Prostate) | Cancer (Other) | Blood Disorders |

| RELATIVE | LIVING OR DECEASED WITH AGE |
|---|---|
| Father | |
| Mother | |
| Siblings | |

**Social History:**

With whom does the child live:_____

Has the child ever been a victim of sexual, emotional, or physical abuse? If so, please describe:_____

Is the child exposed to second hand smoke?_____

What type of water source is in the home: County_____ Well_____

**Patient Name:** _____ **Date filled out:** _____

**Georgia Department of Human Resources (DHR)**
**Division of Public Health**

**Georgia Department of Human Resources**
**Georgia Childhood Lead Poisoning Prevention Program**
**Lead Risk Assessment Questionnaire**

**Please answer yes, no, or I don't know**

1. Does your child live in or often visit a house that may have been built before 1978?

2. Does your child live in or often visit a house that is being remodeled or is having paint removed?

3. Does your child live with or often visit another child that has an elevated blood lead level?

4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?

5. Does your child chew on or eat non-food items like paint chips or dirt?

6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

When using the questionnaire, blood lead tests should be done immediately if the child is at high risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead exposure.

**Patient Name:**_____ **Date filled out:**_____

**Division of Public Health,**
**Prevention Services Branch**
**Tuberculosis Program**
**404-657-2634 fax: 404-463-3460**
**http://health .state.ga.us/programs/tb**

**Tuberculosis (TB) Risk Assesment**
**Child Health Services**

Circle Yes or No

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray? Yes No

2. Has the child been in close contact to a person sick with active TB disease? Yes No

3. Was the child born outside the United States or has the child traveled outside the United States? Yes No

4. Does the child have a household member who was born outside the United States or who has traveled outside the United States? Yes No

5. Is the child exposed to a person who
   - Is currently in jail or who has been in jail in the past 5 years?
   - Has HIV?
   - Is homeless?
   - Lives in a group home?
   - Uses illegal drugs?
   - Is a migrant farm worker? Yes No
   -

6. Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system? Yes No

7. Is the child/ teen in jail or ever been in jail? Yes No

# REQUEST FOR RELEASE OF INFORMATION

I hereby authorize use and/or disclosure of protected health information (PHI) about me as described below. By signing, I authorize

_____(Practice/ Doctor Name)

_____(Address)

_____(**Phone & Fax**)

**Must have the above information to proceed with request**

to disclose certain PHI about me to: High Mountain Healthcare LLC
63 Pleasant Hill Rd. Blairsville, GA 30512
Phone: 706-745-2229 Fax: 706-745-0836

**Please send any of the following:**
Radiology reports
Labs
Hospital discharge records
Growth charts & immunizations (if children)
Special studies (stress tests, cardiac caths, ekg, ect.)
Office notes (last year or last available office note if it has been over a year since patient has been seen)

****If you are sending more than 20 pages, please mail to the above address****

This information will be used or disclosed to aid in the diagnosis and/or continuing treatment of the patient.

I may revoke this authorization by notifying the provider named above in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign it.

This authorization expires one year from date signed, or upon written notice of cancellation by me to the provider.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

_____ _____
Print patients name Print legal guardians name if applicable

_____
Patient Date of Birth

_____ _____
Patient or legal guardians signature Date