Dear New Patient,

We at Rocky Mountain Family Medicine wish to take a moment to welcome you to our practice. Rocky Mountain Family Medicine provides medical care to patients of all ages. Our philosophy is to provide comprehensive medical care, while treating every patient with dignity and respect. We want to sit down and talk with patients, and provide patients with ample opportunity to discuss medical concerns with us. We see patients for many types of medical concerns. We treat a wide spectrum of both acute illnesses and chronic conditions. Preventive care is also critical for ensuring your health, and we take that very seriously. From performing sports physicals each season, to providing cancer and osteoporosis screening, our primary focus in on caring for you. Please do not hesitate to call us to discuss your medical needs.

In this package, you will find Contact Information to help make your first trip easier. You may also want to print an extra copy of that page to keep on hand in case of emergency.
Our HIPPA Privacy Policy is also included, please read this. You will also find two forms that you should fill out and bring with you to your first appointment; they are the Patient Intake Form, and a form to acknowledge receiving the Privacy Policy.

We look forward to seeing you at the clinic, and we will do our best to make your visit as pleasant, efficient, and complete as possible. Thank you for giving us the opportunity to serve you and your family.

Sincerely,
Rocky Mountain Family Medicine

ROCKY MOUNTAIN FAMILY MEDICINE

Patient's Full Legal Name ____
Street Address ____
City ______________________________________State________________ Zip __________________
Home Telephone: (_____) ______________ Date of Birth______ /______ /____ Sex: Male Female
Social Security #: _______-_____ -_______ Marital Status: Single Married Divorced Separated
Employer Name _________________________________ Work Phone ____________________________
Employer Address ___________________________ City______________ State____ Zip______________
Occupation________________________ Spouse's Full Legal Name_______________________________
Cell Phone: (____) _________________
Can we leave messages regarding your care (i.e. lab results, x-ray results) at this number? Yes No

REASON FOR VISIT:

INSURED OR RESPONSIBLE PERSON OR PARENT INFORMATION *if the patient is not responsible for payment*
Name of Person Who Carries the Insurance_________________________ Relation to Patient_________
Address (if different from patient)
____
City __________________________________ State__________________ Zip______________________
Home Telephone: (____) ________________ Work Telephone: (_____) ___________________________
Social Security #: ______-_____ -______ Date of Birth____ /____ /____ Sex: Male Female

INSURANCE INFORMATION
Insurance Name ____ Group Number___________________
Address: Policy Number ____
City __________________________________ State__________________ Zip______________________
Policyholder Name (who carries the insurance) ____
Telephone Authorization or Referral # __________________ Copayment __________________________

EMERGENCY CONTACT *someone not living in your household*
Name ____Relationship to Patient ________________
Home Telephone: (____) ________________ Work Telephone: (_____) ___________________________

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS
I understand that I am financially responsible and agree to pay all of the charges that are not paid by or billed to insurance or any other third party payer. I authorize payment directly to Rocky Mountain Family Medicine, PC for all benefits otherwise payable to me.

CONSENT AND DISCLOSURES
I voluntarily consent to treatment for myself and/or my dependents.

RELEASE OF INFORMATION
I authorize Rocky Mountain Family Medicine, PC to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization review, transfer, and follow-up purposes. I understand that a copy of this agreement maybe used with the same effectiveness as an original.

____
Signature of Patient/ Responsible Party Date

Health Summary

Patient Name (please PRINT) ______________________ DOB ____________

Allergies:

☐ None

Medications:

☐ None What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the-counter)?

Present Health Conditions:

Yes	No	Disease	Yes	No	Disease
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Gout
		Heart Attack			Arthritis
		Heart Murmur			Skin Disease, Type:
		Rheumatic Fever			Stroke
		High Cholesterol			Epilepsy/Seizures
		High Blood Pressure			Diabetes/High Blood Sugar
		Asthma			Thyroid Problems - too high or too low
		Emphysema/Chronic Bronchitis			Anemia/Low Blood
		Blood Clot in Lung			Bleeding Problems, Type:
		Blood Clot in Leg			Blood Transfusion
		Tuberculosis			Cancer, Type:
		Gallstones			Anxiety
		Liver Disease, Type:			Depression
		Ulcers in Bowel/Stomach			Glaucoma
		Bleeding from Bowels			Other:
		Kidney Disease, Type:			
		Kidney Stones			

Surgeries

Yes	No	Disease	Yes	No	Disease
		Cataract Surgery, Left Right			Joint Replacement of Knee/Hip
		Tonsils Removed			Back Disc Surgery
		Neck Artery Surgery			Prostate Surgery
		Open Heart Surgery/Catheterization			Hernia Surgery
		Appendectomy			Vasectomy
		Gallbladder Removal			Hysterectomy
		Abdominal Surgery			Other:
		Broken Bone Repair			
		Joint Scope Surgery			

Family History

Yes	No	Disease	Relation to You	Yes	No	Disease	Relation to You
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout/Arthritis				Anxiety or Depression	
		Osteoporosis				Glaucoma	
		Stroke				Other:	
		Epilepsy/Seizures					

Other History

Exercise: ☐ Never ☐ Rarely ☐ Other:

When was your last:

Tetanus ☐ Never	Hepatitis B ☐ Never	Pneumovax ☐ Never
Flu Shot ☐ Never		

Smoking:

Have you ever smoked? ☐ Yes ☐ No

How many years did you smoke? ____________

When did you quit? ____________

How many packs per day do you smoke now? ____________

Do you use smokeless tobacco? ☐ Yes ☐ No

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:

☐ Yes ☐ No Do you drink? How much? ____________ How Often? ____________

☐ Yes ☐ No Do you use drugs? How much? ____________ How Often? ____________

What kind? ____________

What drugs have you used in the past? ____________

Female Patients Only

of Pregnancies: # of Deliveries: # of Elective Abortions: # of Miscarriages:

When was your last menstruation? ____________ How old were you when you went through Menopause? ____________

When was your last Pap Smear? ____________ Have you ever had an abnormal Pap Smear? ☐ Yes ☐ No

If 'Yes', when was the abnormal Pap smear? ____________

What was the abnormality? ____________

What kind of treatment did you have? ____________

When was your last Mammogram? ____________ Have you ever had an abnormal Mammogram? ☐ Yes ☐ No

If 'Yes', when was the abnormal Mammogram? ____________

The above information is current and correct to the best of my knowledge.

Patient/Guardian Signature Date

I have reviewed the above history.

Physician Initials Date

Authorization for Release of Medical Records

Rocky Mountain Family Medicine, P.C.
13650 E. Mississippi Avenue, Suite 120
Aurora, CO 80012
Telephone: 303-695-8684 Fax: 303-695-8814

Patient Name ____

Date of Birth ______________________ Responsible Party: ________________________________

Social Security Number ____

I hereby authorize ____ to release my medical records to Rocky Mountain Family Medicine, P.C.

In regard to the period from __________________________ to______________________________.

The information to be released may include appropriate medical information about past medical care. Items specifically requested to be released should include:

History & Physical: _______

HIV Test: _____

Progress Notes: _________

Other: ____________________________

Lab Reports: ____________

X-Ray Reports: __________

I understand that this authorization will automatically become null and void upon release of the requested information. I also understand that this authorization will automatically become null and void ninety (90) days after signature of this authorization.

This information has been disclosed to us from the records whose confidentiality is protected by Federal Law. Federal regulations (42 C.F.R. Part 2) prohibit us from making any further disclosure of it without specific written consent of the person to whom it pertains or the guardian legally appointed therefore; a general authorization for the release of this information is not sufficient for this purpose.

A facsimile (fax) of this authorization will suffice.

Patient Signature ____ Date ________________

Guardian Signature *(if necessary)*:____

CLINIC POLICIES FOR NEW PATIENTS

Discounts and Payment Responsibilities

We offer a 10% discounted rate for patients that do not have insurance and pay for their visit, **IN FULL**, at the time services are rendered. We take an estimated amount in the form of a deposit before the time of the examination and any additional services that are provided must be paid **IN FULL** at the end of the visit.

Late/No Show Policy

Please be advised that you are expected to arrive 15 minutes prior to your appointment time in order to allow for check-in and registration.

If you arrive later than 20 minutes after your scheduled appointment time, you may be asked to re-schedule or be seen as a walk-in if there is a provider available.

If you are unable to make your appointment, please call and re-schedule so that other patients can be accommodated. **If you do not show up for your appointment and do not call during business hours to cancel at least 24 hours prior to your appointment, you will be considered a no show. You will be charged a $50.00 no show fee for a regular office visit and a $75.00 no show fee for a missed physical.** Once you have acquired three no shows or late appointments, you may be asked to find a new primary care provider.

Co-payments and Deductibles

Your co-payment is required as part of a contractual agreement between you and your insurance company that you are expected to pay at the time of your visit. **If you are unable to pay your co-payment at the time of service, you will be charged a $25.00 missed co-pay fee.**

If you have an un-met deductible, we will collect the amount of the visit up to the un-met deductible amount. Any overages paid will be refunded to you.

Laboratory testing

A provider may need to rely on results of laboratory testing along with a physical exam to determine a diagnosis and course of treatment. We perform a few simple laboratory tests (urinalysis, strep, urine pregnancy, and mono) here at our clinic.

Some tests may need to be sent to an outside lab for further examination. You will receive a separate bill from the laboratory for which you will be responsible. Your medical insurance frequently pays for all or a portion of these charges. If you do not have insurance, you are eligible to receive discounts for some tests. Please ask the nurse for more details.

Prescription Refill Requests

It is our policy that all prescription refill requests are processed within 24-48 hours from the time of the request. Please understand that prescription refills may not be authorized by the provider.

After Hours Physician Line

We have a provider “on call” after our office is closed to take care of your **urgent,** after-hours medical needs. No refills on medications will be done after hours.

Forms

A fee will be charged for the completion of forms, letters, or additional paperwork that you request from the provider. The fee for the first 2 pages is $10.00. After the first two pages, the flat-rate fee is $50.00. Alternatively, you may schedule an appointment with the provider to have the forms completed at an office visit. For completion of forms outside an office visit, payment will be collected at the time the forms are picked up. Forms require 3-5 business days to be completed.

Release of Information

I authorize Rocky Mountain Family Medicine to release (verbally or in writing) confidential medical information to any person or entity which may be liable to me or my Practitioner(s) for charges for this treatment, and for quality management, utilization, review, transfer and follow-up purposes. I understand that a copy of this agreement may be used with the same effectiveness as an original.

Consent and Disclosures

I voluntarily consent to treatment for myself and/or my dependents.

Financial Agreement and Assignment of Benefits

I understand that I am financially responsible and agree to pay all of the charges that are not covered by my insurance or any other third party payer. I authorize payment directly to Rocky Mountain Family Medicine for all benefits otherwise payable to me.

I fully understand all of the above policies and procedures and agree to these terms and conditions by signing below.

______________________________________ ________________________

Patient/Guardian Signature Date

Rocky Mountain Family Medicine

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

The clinic is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of Your Health Information for Treatment Purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of Use of Your Health Information for Payment Purposes:

We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the clinic. The information in it, however, belongs to you. You have a right to:

• Request a restriction on certain uses and disclosures of your health information by delivering the request to our clinic -- we are not required to grant the request, but we will comply with any request granted;

• Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our clinic;
• Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our clinic;

• Appeal a denial of access to your protected health information, except in certain circumstances;

• Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our clinic. We may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information kept by or for the clinic;
- Is not part of the information that you would be permitted to inspect and copy; or,
- Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

• Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our clinic;

• Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our clinic. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.

• Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our clinic, except to the extent information or action has already been taken. If you want to exercise any of the above rights, please contact Dr. Nathan Moore, President, at our office at 303-695-8684, Rocky Mountain Family Medicine, 13650 E. Mississippi Avenue, Suite 120, Aurora, CO 80012, in person or in writing, during regular, business hours. He will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The clinic is required to:

• Maintain the privacy of your health information as required by law;

• Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;

• Abide by the terms of this Notice;

• Notify you if we cannot accommodate a requested restriction or request; and,
• Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Nathan Moore, President, at our office at 303-695-8684, Rocky Mountain Family Medicine, 13650 E. Mississippi Avenue, Suite 120, Aurora, CO 80012.
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our clinic by delivering the written complaint to Dr. Nathan Moore, President, at our 303-695-8684, Rocky Mountain Family Medicine, 13650 E. Mississippi Avenue, Suite 120, Aurora, CO 80012. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and email address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

• We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the clinic.

• We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

• Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

• Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Disaster Relief

• We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

• Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA)

• We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

• If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

• As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

• We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Employers

• We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutions

• If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

• We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

• Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

• We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

• To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

• We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

• We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

• Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Rocky Mountain Family Medicine

____ ________________________

Name of Patient (please print) Date of Birth

I hereby acknowledge that I read and/or received Rocky Mountain Family Medicine's Notice of Privacy Practices.

____ ________________________

Signature of patient or patient representative Date

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's
Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the clinic on ______________________________________ and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient refused to sign.

Patient was unable to sign or initial because:

____

____

The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

Other reason (describe below):

____

____

____ ________________________

Signature of Employee Completing Form Date