Acct #: _______________

Current Patient Information Update 2021

Date: _________________

Patient Information

Patient Name: ____ DOB: _________________

Address: ____

Home Phone: _________________________________ Work Phone: ________________________

Cell Phone: ___________________ (Required for reminder texts)

Email: ____

Marital Status: ___ Married ___ Single ____ Divorced ___ Widowed ___ Partnered ___Other:____________

Preferred Pharmacy: ______________________Location: _______________ Phone Number: ___________________

Emergency Contact: __________________________ Phone: _________________ Relationship: _________________

Primary Insurance Information

Carrier: _______________________ ID#: _________________________ Group#: _________________________

Claims Address: ____

Policyholder Information if other than self

Name:____ DOB:_______________________

Address (If different):____

Financial Responsibility

As a courtesy, Rocky Run Family Medicine sends claims to primary, and in many cases, secondary insurances. We do **NOT** send claims to automobile insurances for motor vehicle accidents. For a workers' compensation visit, you must provide us with your company information so the office visit does **NOT** get billed to your insurance.

It has been our policy since 2006 that additional fees apply to missed appointments, as well as cancelled/changed appointments if not cancelled/changed more than one business day in advanced (i.e. same time as appointment on prior business day).

It is fraud to misrepresent or misinform us of your insurance policy or information.

I certify that all the above information is correct and up to date. _______

I understand that copays, coinsurances, deductibles, and denied charges are my responsibility. _______

I understand the policy for missing, cancelling, changing, and being late to appointments. __________

Patient/Guardian Name: ________________________________ Signature: ________________________________

HIPAA Consent Form

Must be completed at the first visit of each calendar year for each patient

I understand that as part of my healthcare, Rocky Run Family Medicine maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that the services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have access to a HIPAA Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practice. I also understand that I have the right to restrict how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is required to agree to the restrictions requested. I understand that I may revoke this consent in writing. Any patient, guardian, or personal representative has the right to request confidential communication of PHI. Such requests must be in writing and the practice will accommodate reasonable requests.

With this consent, Rocky Run Family Medicine may mail to my home or other designated location any appointment reminders and other correspondence marked personal and confidential that assist the practice in carrying out treatment, payment, and healthcare operations.

By signing this form, I am giving my consent to Rocky Run Family Medicine to use and disclose my PHI to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing.

Patient Name:____ DOB:_________________________

Signature:____ Date:_____________________________

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This authorization grants permission for the party (parties) named below to: have access to medical information, laboratory results, test findings, and telephone communication; pick up medications, referrals, and notes; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial information. Also included is an authorization to leave similar medical information on a private phone or voice messaging system

I understand this authorization is voluntary.

Patient's Name: ________________________________ Date of Birth: _______________________________

I request and authorize ___________________Rocky Run Family Medicine______________________________
to release healthcare information of the patient named above as follows:

Name:___________________________ Relationship to Patient:_____________________________
Name:___________________________ Relationship to Patient:_____________________________
Private number / voicemail on which messages may be left: _______________________

☐ Check here if you do not authorize anyone else to have access to your information or have any number on record for leaving detailed messages

I understand that this authorization will (check 1):
- ☐ Expire 1 year from the date signed by the patient
- ☐ Be effective for the lifetime of the patient unless revoked in writing
- ☐ Be effective until _______________________

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates:____

☐ All healthcare information (except as noted below)

☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) or number listed above.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) or number listed above.

Patient Signature: ____ Date: ______________________________