

Patient Information

Patient Name: _____ Date: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____)____-____ Cell Phone: (____)____-____ (for reminder texts)

Work Phone: (____)____-____ Email: _____

Sex: Male Female

Gender ID: Male Female Female-to-Male Male-to-Female Genderqueer Other

Sexual Orientation: Heterosexual Homosexual Bisexual Other: _____

Marital Status: Single Married Divorced Widowed Partnered Other: _____

Race: White White European African American American Indian, Alaska Native

Asian Native Hawaiian, Pacific Islander Other: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Decline

Smoking status: Never Current every day Current some days Former Unknown

Emergency Contact: _____ Phone: (____)____-____ Relation: _____

Preferred Pharmacy: _____ Location: _____ Phone: (____)____-____

Primary Insurance Information

Carrier: _____ Member ID#: _____ Group#: _____

Claims Address (on back of card): _____

Policyholder Information (if other than Self):

Name of policyholder: _____

DOB: _____

Address (if different): _____

Financial Responsibility

As 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 visit does **NOT** get billed to your insurance. It is fraud to misrepresent or misinform us of your insurance policy or information.

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

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, canceling, changing, and being late to appointments.

Initial

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 Name: _____ DOB: _____

Select one of the following:

I **DO NOT** authorize anyone else to have access to the above patient's information nor have any number on record for leaving detailed messages.

I request and authorize **Rocky Run Family Medicine** to release healthcare information of the above patient to the following listed members.

- Name: _____ Relationship to patient: _____
- Name: _____ Relationship to patient: _____
- Name: _____ Relationship to patient: _____
- Private number/voicemail on which messages may be left (can be own #): (____)____ - _____

If authorization is granted, please fill below. Otherwise, skip to the bottom of the page and sign.

1. I request that the authorization granted to the above members (select one):

- Is effective for the **lifetime** of the patient unless revoked in writing
- Expires **1 year** from today's date
- Is effective until: _____

2. This request and authorization applies to (select one):

- All healthcare information
- Healthcare information only related to the following condition, treatment, or date range:

Other criteria: _____

3. **Other records:** Sexually Transmitted Diseases (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papillomavirus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

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

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

Patient/Guardian Name: _____ Signature: _____

Patient Medical History

Please indicate if you currently have or have had any of the following:

	Yes	No	Details		Yes	No	Details
Headaches, Migraines				Abdominal Pain			
Epilepsy, Seizures				Bowel Irregularity			
Depression				Rectal Bleeding			
Anxiety				Hemorrhoids			
Mental Health Issues (list specifics)				Hernia			
				Gallbladder Disease			
Insomnia				Bladder Infections			
Sleep Apnea				Incontinence			
Hearing Loss				Prostate Problems			
Ringing in Ears				Kidney Disease			
Glaucoma/ Cataracts				STD			
Fatigue				HIV/AIDS			
True Food Allergies				Hepatitis			
Stroke				Sexual Dysfunction			
Eating Disorders				Menstrual Dysfunction			
Thyroid Disease				Infertility			
Dizziness/Fainting				Arthritis			
Weakness				Osteoporosis			
Chest Pain				Neck Pain			
Heart Murmur				Back Pain			
Heart Palpitations				Bursitis/Tendonitis			
Heart Disease				Hives			
Elevated Cholesterol				Chronic Rash			
High Blood Pressure				Diabetes			
Low Blood Pressure				Cancer			
Circulation Problems				Weight Loss			
Bleeding Tendency				Weight Gain			
Anemia				Measles			
Blood Transfusion				Mumps			
Leg Pain/Swelling				Chickenpox			
Shortness of Breath				Whooping Cough			
Wheezing				Polio			
Asthma				Tetanus			
Pneumonia				Erectile Difficulties			
Tuberculosis (TB)				Any Other Illnesses/Diseases			
Indigestion/Heartburn							
Ulcer							

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Social History

	Yes	No	Details		Yes	No	Details
Smoke (list # per day and for how many years)				Caffeine Use (how much)			
Alcohol (list frequency and amount)				Exercise Outside of Daily Activities (what/how often/how long)			
Use Drugs				Employed (list occupation)			
Live Alone				Under Stress			
Have Children (how many/sex/birth year)							

Surgical History

	Yes	No	Details		Yes	No	Details
Tympanostomy (ear tubes)				Hysterectomy			
Appendectomy				Hip Replacement			
Gallbladder Surgery				Knee Surgery			
Heart Surgery (indicate what type)				Cataract Repair			
Tonsillectomy				Sinus Surgery			
Bunionectomy				Any Surgeries Not Listed (include only date and year or surgery)			
Back Surgery							

Family History

If yes to any below, please include which family member

	Yes	No	Details		Yes	No	Details
Asthma				Epilepsy			
Heart Disease (note age of first event)				Bleeding Disorder			
High Blood Pressure				Kidney Disease			
High Cholesterol				Thyroid Disease			
Stroke				Mental Illness			
Cancer (type, age)				Osteoporosis			
Glaucoma				Arthritis			
Diabetes				Any Other Illness/Disease Not Listed			

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Females Only

	Yes	No	Details		Yes	No	Details
Age Periods Began				Premature			
Cycle Length (average # days from first day of period to first day of next period)				Stillbirths			
Period Length				Miscarriages			
Flow				Abortions			
Discomfort				Tubal Pregnancy			
PMS (pre-menstrual syndrome)				Pregnancy Complications			
Number of Pregnancies				Vaginal Deliveries (what year/s)			
Full term				Cesarean Sections (what year/s)			

Medications

Please list any medications you are currently taking:

Please list any known drug allergies you have and your reaction to them:
