RRFM Document #UPSPAC2022 Acct #:_____

DOB:_____/_____/_____

Current Patient Information Updates

Patient Information

Patient Name: _____ Date: _____

Address:_____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ **(for reminder texts)**

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

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered ☐Other:_____

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

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

Primary Insurance Information

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

Medical 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).

Initial	
☐	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.

Patient/Guardian Name: _____ Signature: _____

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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:_____

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DOB:_____/_____/_____

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 Rocky Run Family Medicine to release the above patient's information to anyone else 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: _____