

Rocky Vista Health Center

8401 S. Chambers Rd.

Parker, CO 80134

Phone: 720-875-2880 Fax: 720-875-2887

Patient's Full Name: _____ Date of Birth: _____ Age: _____

Gender: Male _____ Female _____

Parent's Full Name: _____

Gender: Male _____ Female _____

Address: _____

Date of Birth: _____

City, State, Zip: _____

Age: _____ SS#: _____

Telephone: (H) _____

Marital Status: M _____ S _____ D _____ W _____

(C) _____

Are you a student at RVU-COM?: _____

Email: _____

Emergency Contact Name: _____ Number: _____

Name of Insurance: _____

Policy #: _____

Subscriber Name: _____

Group #: _____

Subscriber SS#: _____

Subscriber DOB: _____

(Please make sure to bring a copy of your current insurance card and driver's license to your appointment)

How did you hear about us?

Primary Care Physician: _____ Phone #: _____

Last visit to this physician: _____

Current Medical Problems:

(Medical problems that you child is under treatment for by another physician/PT/chiropractor also include those problems with behavior modifications/therapy or daily or as needed medications.)

Allergies:

- Is your child allergic to any medications? Yes ___ No ___ If yes, please list:

Name of drug _____ Date of 1st reaction & type of reaction _____

Name of drug _____ Date of 1st reaction & type of reaction _____

Name of drug _____ Date of 1st reaction & type of reaction _____

- Is your child allergic to any foods? Yes ___ No ___ If yes, please list:

Type of food _____ Date of 1st reaction & type of reaction _____

Type of food _____ Date of 1st reaction & type of reaction _____

- Is your child allergic to any environmental allergens? Yes ___ No ___ If yes, please list:

Type of allergen _____ Date of 1st reaction & type of reaction _____

Type of allergen _____ Date of 1st reaction & type of reaction _____

Medications: (Please list all current medications)

1. Name _____ dose _____ How many times a day _____

2. Name _____ dose _____ How many times a day _____

3. Name _____ dose _____ How many times a day _____

4. Name _____ dose _____ How many times a day _____

Past Medical History: (Which of the following conditions has your child been treated for in the past)

HEENT:

- Vision correction Snoring Enlarged tonsils
 Nose bleeds Frequent throat infections Cataract

Cardiovascular:

- Murmur Arrhythmia High blood pressure
 Congenital heart disease Blood clots

Respiratory:

- Asthma Pneumonia Sleep apnea

Gastrointestinal (GI):

- GI reflux (GERD) Chronic diarrhea Chronic vomiting
 Crohn's disease Irritable bowel (IBD) Gastric/duodenal ulcers
 Hepatitis

Renal/GU:

- Urinary tract infection (UTI) Congenital renal anomaly
 Urinary reflux (VUR) Kidney stone STD
 Labial adhesions

Endocrine:

- Thyroid problems (high or low) Diabetes (type 1 or type 2)

Neurologic:

- Headaches/migraines Seizures Muscular dystrophies
 ADD/ADHD

Musculoskeletal:

- Back pain Arm pain Leg pain
 Hip pain Knee pain Joint pain (where?) _____

Hematologic:

- Anemia Leukemia Thalessemia

List any complications during pregnancy: (include maternal medical problems, high blood pressure, gestation diabetes, premature rupture of membranes, preterm labor, STDs, IUGR, multiple gestations, etc.)

Labor/Delivery

Gestational age at delivery: _____

C-section or vaginal delivery (circle one) If C-section give reason why: _____

Singleton, twins, triplets or other (circle one)

APGARS 1 minute _____ 5 minute _____ Birth weight: _____ Birth Length: _____

List any complications at the time of delivery: (include abnormal fetal heart rate, breech position, maternal GBS, fever, high BP, narcotics <6hr prior to delivery, meconium stained fluid or aspiration, precipitous delivery, use of magnesium, forceps or vacuum delivery, etc)

Social History:

Mom's marital status: _____ Dad's marital status: _____

Mom's occupation: _____ Dad's occupation: _____

Near-by relatives for support? Yes/No (circle one) Who? _____

Attendance at daycare or school? Yes/No (circle one) If yes, how often and what is the name of the school?

Who lives in the home with your child? (ie. mom, dad, grandparent,etc)

Does anyone with significant exposure to your child smoke cigarettes? Yes/No (circle one)

Family History:

| | Age | Deceased (Y/N) | Health Status/Medical Problems |
|-------------------------------|-----|----------------|--------------------------------|
| Mother | | | |
| Father | | | |
| Child's Sibling: _____ (name) | | | |
| Child's Sibling: _____ (name) | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |

Reason for today's visit:

Is your child experiencing any of the following symptoms in the past 1 month?

- General: Fever/chills Weight loss Fatigue
- HEENT: Blurred vision Eye discharge/redness Runny nose
- Nasal congestion Ear pain/pulling on ears Nose bleeds
- Sore throat Lymph node enlargement
- Pulmonary: Cough Difficulty breathing Wheezing
- Shortness of breath Pain with breathing
- Cardiovascular: Chest Pain Edema/swelling racing heart beat

- GI: Abdominal pain Nausea Vomiting
 Diarrhea Constipation GI reflux
 Blood in stool
- GU: Frequent urination Burning with urination Urgency
 Blood in urine
- Neurologic: Weakness Numbness Dizziness
 Headaches
- MSK: Neck pain Shoulder pain Upper back pain
 Lower back pain Hip pain Arm pain
 Leg pain Knee pain Ankle/foot pain
- Skin: Rash (where? _____) Acne

Immunization History:

Date of last routine childhood vaccination. _____

Has your child had a positive PPD or been exposed to a person with TB in the past?

Yes/No (circle one)

***Please provide us with your child's most recent immunization records.**

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on these pages is complete, true and accurate.

Patient/Legal Guardian Signature _____ Date _____

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Statement of Financial Responsibility

1. Private insurance authorization for assignment of benefits and release of information

I hereby authorize and direct payment of my medical benefits to Rocky Vista Health Center, for any services furnished to me by the physicians. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical services to third party payers and/or health practioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

_____Initials

2. Payment

I hereby assume responsibility to pay the costs of all services provided to me by Rocky Vista Health Center and its physicians.

_____Initials

3. Authorization of Payments

I understand that Rocky Vista Health Center will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Rocky Vista Health Center and its physician(s) of medical benefits, otherwise payable to me, for the services provided. I understand that I am financially responsible for my health insurance deductibles, coinsurance (co-pays) and non-covered services.

_____Initials

4. Laboratory Bills

I understand the outside reference laboratory will bill me directly for all laboratory tests performed by the company. I understand that fee schedule (cost) for laboratory tests performed by the Health Center shall be available to the patient upon request.

_____Initials

5. Teaching Facility

I have been informed and understand that Rocky Vista Health Center is a teaching facility. I hereby authorize that a medical student and/or a resident under the supervision of an attending physician may render my medical care jointly. I authorize the medical student and/or resident to communicate my diagnosis and treatment with his or her supervising attending physician, as well as, with other health care practioners involved in my care. I authorize the admittance of qualified observers, including medical students, during my consultation and/or examination.

_____Initials

6. Medicare Lifetime signature on File

I request that payment of authorized Medicare benefits be made to Rocky Vista Health Center for any services furnished to me by the physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services

_____Initials

7. Medigap Authorization for Assignment of Benefits and Release of Information

I request that payment of authorized Medigap benefits be made to Rocky Vista Health Center for any services furnished to me by the provider of service. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits payable for related services.

_____Initials

Signature

Date

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Rocky Vista Health Center is staffed and patient care is provided by licensed Colorado physicians and other health care professionals who are faculty of the University and its Colleges. The faculty commits time to teaching and the academic evaluation of students and residents, as well as providing clinical services and caring for patients of the Health Center.

As a patient of the Health Center, you have a right to:

- Know the identity, professional status and experience of those with whom you interact.
- Make choices regarding your healthcare professional.
- Receive considerate, professional, respectful and private care.
- Expect effective communication that maintains confidentiality.
- Expect your privacy to be respected to the fullest extent possible, and expect confidentiality of your medical records and communications.
- Expect that every professional with whom you interact will fully comply with HIPAA and other law or regulation pertaining to the delivery of healthcare.
- Receive complete and understandable information regarding your diagnosis, options, risks and alternatives.
- Refuse or withdraw your consent at any time and discontinue any treatment, drug or procedure.
- Be provided timely access to your medical records for review.
- Request an estimate of charges prior to receiving non-emergency care.
- Request an explanation of all billing charges and procedures, and expect a timely resolution of all billing concerns.
- Register a complaint or concern regarding your care with the Office Manager or Medical Director and to have those concerns addressed without fear of recrimination or penalty.

In certain circumstances, Federal or State laws or regulations may impose certain limitations on your ability to exercise any of the rights listed above.

As a patient, you have the responsibility to:

- Provide complete and accurate health information.
- Ask questions that are significant for your health care.
- Participate with your provider in the development and implementation of your plan of care.
- Take responsibility for refusing treatment, withdrawing consent, or failing to follow a plan of care.
- Report any worsening of your condition or unexpected reactions to medications promptly.
- Keep appointments, and follow the Health Center's cancellation policy.

I have read and understood the foregoing and agree to adhere to Rocky Vista Health Center's Patient Rights and Responsibilities.

Printed Name of Patient/Legal Representative

If Legal Representative, relationship to Patient

Signature of Patient/Legal Representative

Date

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Welcome to Rocky Vista Health Center. All of our physicians and staff members are very glad to have you as a patient in our clinic. We strive to provide our patients with the best care possible. We have several rules we would like to make you aware of. If you have any questions or concerns about these rules, don't hesitate to ask the receptionist. We'll be happy to answer all of your questions.

1. Our center is open Monday through Friday from 8am to 5pm, excluding Holidays.
2. If you have a true emergency, please call 911 or go to the nearest emergency room.
3. We will make every attempt to accommodate urgent requests for same-day appointments. Please try and call as early as possible to give us the ability to better accommodate your request.
4. Walk-ins are discouraged. Please try to call our office before you come. If you come without an appointment, we will try to "fit you in", but you may experience a long wait.
5. Your doctor may not be in the clinic every day. All non-urgent appointments will be made with your doctor, but if you need an urgent appointment, one of the other doctors working that day may see you.
6. When the center is closed, we will have an on-call physician available. Call the office number and you will be directed to the physician. On-call physician is available only for urgent situations. No medication refills will be given and no appointments will be scheduled on a weekend or after hours. Patients who frequently call on-call physicians for non-urgent questions will be warned, and may be discharged from the practice.
7. Always bring your ID, insurance information and list of your current medications to your appointment.
8. We have a 24-hour cancellation policy. All patients who miss their appointments or fail to cancel without a 24-hour notice will be charged a \$25 cancellation fee.
9. Please be on time for your appointment. If you are more than 10 minutes late, you may be asked to reschedule.
10. All payments are due the day of your appointment
11. Please call all your medication refills at least 5 days in advance to your local pharmacy.
12. We don't give refills of controlled substances (such as narcotic pain medications, anxiety benzodiazepines etc.) to new patients unless medical records from previous health care providers outlining the reason those medications were prescribed are brought by the patients to their appointment.
13. There is a 7-14 day turn around on all medical record requests or physician forms to fill out.

Once again, we are delighted that you have chosen Rocky Vista Health Center to meet all of your Health Care needs.

Patient/Legal Guardian Name

Patient/Legal Guardian Signature

Date

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How can we reach you?

Rocky Vista Health Center, at times, may need to contact you about test results, appointments, referrals or billing/insurance. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a policy on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave messages on voice mail or answering machines
- We will NOT send emails/faxes

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ give my permission for Rocky Vista Health Center to leave phone messages and/or email/fax messages, regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient Name _____
Date of Birth _____

How would you prefer to receive NORMAL test results?

- Email Email Address: _____
- Fax Fax Number: _____
- Phone Number: _____

May we leave a phone message to inform you that test results are available and to contact our office for those results?

- Home Phone: _____
- Work Phone: _____
- Cell Phone: _____