ROCKY VISTA HEALTH CENTER
Patient Registration Form

Patient Information

Last Name:	First Name:	MI:	DOB:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Email:	☐ Male ☐ Female

Marital status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life partner

Insurance Company Name: Provide your card to the receptionist

Pharmacy name and cross streets:	Pharmacy phone number:

Responsible Party-COMPLETE ONLY IF DIFFERENT FROM PATIENT

Last Name:	First Name:	MI:	DOB:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Email:	☐ Male ☐ Female Relationship to patient: _____

Emergency Contact

Last Name:	First Name:	MI:	DOB:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Email:	Relationship to patient:

Contact Preferences

Rocky Vista Health Center may need to contact you regarding test results, appointments, referrals or billing/insurance information. In an effort to protect your privacy, please complete the following information to allow us to leave detailed messages in regards to your health care.
*Rocky Vista Health Center does NOT have secure email; therefore we recommend registering for our patient portal for access to your health care needs

I give Rocky Vista Health Center permission to contact me in the following manner, including detailed information regarding my health care.
☐ Home number listed above, ok to leave message with detailed information ☐ Home number, do NOT leave message
☐ Cell number listed above, ok to leave message with detailed information ☐ Cell number, do NOT leave message

I, _____ give my permission for Rocky Vista Health Center to leave phone messages regarding my medical care or account information with:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I acknowledge that the information above is true and accurate for the patient listed on this registration form.

Signature: _____ Date: _____

Printed Name: _____

ROCKY VISTA HEALTH CENTER
Patient Medical History Form

Date	Patient's Name	DOB	Age	M ☐ F ☐

Previous Physician/Office	Request for Records Transfer Complete ☐ Y ☐ N	Date of Last Physical

Advanced Directives

☐None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living ☐ HC Proxy Date Reviewed: _____ Physician: _____

Medications-List all medications you take, prescription and non-prescription and their dosage

☐ I do not take any medications

Medication name	Dosage	Medication name	Dosage

Allergies-medications, food, animals, etc.-List all know allergies

☐ No known allergies

Allergy	Reaction	Allergy	Reaction

Current and Past History-Please check if you have ever experienced any of the following conditions and the year of onset

Condition	Year	Condition	Year
☐ None		☐ Gallbladder disease	
☐ Allergies		☐ GERD (reflux)	
☐ Anemia		☐ Hepatitis C	
☐ Angina		☐ Hyperlipidemia (high cholesterol)	
☐ Anxiety		☐ Hypertension (high blood pressure)	
☐ Arthritis		☐ Irritable bowel disease	
☐ Asthma		☐ Liver disease	
☐ Atrial fibrillation		☐ Migraine headaches	
☐ Benign prostatic hypertrophy		☐ Myocardial infarction	
☐ Blood clots		☐ Osteoarthritis	
☐ Cancer, type: _____		☐ Osteoporosis	
☐ Cerebrovascular accident		☐ Peptic ulcer disease	
☐ Coronary artery disease		☐ Renal disease (kidney)	
☐ COPD (emphysema)		☐ Seizure disorder	
☐ Chon's disease		☐ Thyroid disease	
☐ Depression		☐ Other, _____	
☐ Diabetes		☐ Other, _____	

Any other medical or mental health issues/problems _____

_____

Do you see any specialists? ☐ Y ☐ N If yes, Who?_____

For what reason or diagnosis? _____

Do you have any other issues or concerns not listed above? _____

_____

Do you have children? ☐ Y ☐ N How many? _____ Females: _____ Males: _____

Tobacco use:	☐ Never ☐ Y ☐ N ☐ Former, year quit: _____ Type: ☐ Chewing ☐ Pipe ☐ Cigar ☐ Cigarette ☐ Smokeless ☐ Vape Frequency: ☐ Daily ☐ Some days ☐ Other, _____
Alcohol Use:	☐ Never ☐ Y ☐ N ☐ Former, year quit: _____ Type: ☐ Beer ☐ Liquor ☐ Wine ☐ Other, _____ Frequency: ☐ Daily ☐ Some days ☐ Other, _____
Exercise/Activity:	Level: ☐ Moderate ☐ Sedentary ☐ Vigorous Frequency: ☐ Daily ☐ Some days ☐ Other, _____
Sleep Pattern:	Changes: ☐ Yes ☐ No
Caffeine Use:	☐ Never ☐ Y ☐ N ☐ Former, year quit: _____ Type: ☐ Chocolate ☐ Coffee ☐ Soda ☐ Tables ☐ Tea ☐ Other, _____ Frequency: ☐ Daily ☐ Some days ☐ Other, _____

Surgical History-Please check if you have had any of the following procedures and provide the year it was done

Surgical Procedure	Year	Surgical Procedure	Year
☐ None		MEN ONLY	
☐ Angioplasty		☐ Prostate biopsy	
☐ Angioplasty w/ stent		☐ TURP (trans-urethral resection of prostate)	
☐ Appendectomy		☐ Vasectomy	
☐ Arthroscopy of knee		☐ Other, _____	
☐ Back surgery		☐ Other, _____	
☐ CABG (heart bypass)			
☐ Carpal tunnel release		WOMEN ONLY	
☐ Cataract extraction		☐ Augmentation mammoplasty	
☐ Cholecystectomy		☐ Bilateral tubal ligation	
☐ Colectomy		☐ Breast biopsy	
☐ Colostomy		☐ Cesarean section	
☐ Gastric bypass		☐ D & C	
☐ Hernia repair		☐ Hysterectomy	
☐ Hip replacement		☐ Mastectomy	
☐ Knee replacement		☐ Myomectomy	
☐ LASIK		☐ Reduction mammoplasty	
☐ Liver biopsy		☐ TAH/BSO	
☐ Pacemaker		☐ Vaginal hysterectomy	
☐ Small bowel resection		☐ Other, _____	
☐ Thyroidectomy		☐ Other, _____	
☐ Tonsillectomy		☐ Other, _____	

Family Medical History: Have any family members had the following: This is the relationship to the patient. *Maternal=Mothers side Paternal=Fathers side

Condition	Yes	No	Brother	Daughter	Father	Maternal Aunt	Maternal Grand-Father	Maternal Grand-Mother	Maternal Uncle	Mother	Paternal Aunt	Paternal Grand-Father	Paternal Grand-Mother	Paternal Uncle	Sister	Son	Unspecified Relation
Alcohol/Drug Use																	
Allergies																	
Alzheimer's disease																	
Asthma																	
Blood disease																	
CAD																	
Cancer type: _____																	
CVA (stroke)																	
Depression																	
Diabetes																	
Eczema																	
Hearing deficiency																	
High Cholesterol																	
High blood pressure																	
Irritable bowel disease																	
Learning disability																	
Mental illness																	
Obesity																	
Osteoarthritis																	
Osteoporosis																	
PVD																	
Renal disease																	
Other: _____																	
Other: _____																	

Additional Family History/Comments

_____

_____

Health Maintenance-Please check if you have had any of the following exams and provide the date of the last exam

Exam	Date	Exam	Date
☐ None		☐ GYN exam	
☐ Breast exam		☐ Influenza vaccine	
☐ Cardiac stress test		☐ Lipid panel	
☐ Colonoscopy		☐ Mammogram	
☐ DEXA Scan		☐ PAP test	
☐ Echocardiogram		☐ Physical exam	
☐ EKG		☐ Pneumococcal vaccine	
☐ Eye exam		☐ Pulmonary function test	
☐ FOBT (stool card for hidden blood)		☐ Sigmoidoscopy	
☐ Foot exam		☐ Tetanus vaccine	

ROCKY VISTA HEALTH CENTER
Patient HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how your protected health information about is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Rocky Vista Health Center endorses supports and participates in electronic health information exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the HIE, or cancel an opt-out choice at any time.

The patient understands that:
Your protected health information may be disclosed or used for treatment, payment, or health care operations.

The practice has a Notice of Privacy Practices and that the patient have the opportunity to review this Notice.

The practice reserves the right to change the Notice of Privacy Practices.

The patient has the right to restrict the uses of their information but the practice does not have to agree to the restrictions.

The patient may revoke this consent in writing at any time and all future disclosures will then cease.

The practice may condition receipt of treatment upon the execution of this Consent.

_____	_____	_____
Patient Name	Patient Signature	Date

If the patient refuses to sign the consent, refusal does NOT mean patient cannot be treated, refusal does not affect treatment.

Patient has refused to sign the HIPAA notice.

_____	_____	_____
Employee name	Employee Signature	Date

ROCKY VISTA HEALTH CENTER
Health Center Policies

Patient Name: _____ DOB: _____

The physicians and staff at Rocky Vista Health Center (RVHC) are here to assist you with your medical needs and provide the best care possible. Please read and initial all of the statements below.

_____ *INSURANCE:* I agree to provide information regarding my health care benefits (insurance plan) to RVHC. I understand RVHC will assist me in submitting my claim to my insurance carrier and I assign payment, if any from my insurance plan to RVHC.

_____ For MEDICARE patients ONLY, I certify the information given by to in applying for payment under Title XVII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to RVHC for any services furnished to me by this office and it's physicians. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and it's agents any information needed to determine these benefits or the benefits payment for related services and I request payment directly to RVHC.

_____ *FINANCIAL RESPONSIBILITY:* I understand any portion of any claim that is applied to my co-insurance, deductible, or denied as a non-covered service will be my responsibility and payment will be due upon receipt of my statement. Insurance co-pay is due at the time services are rendered along with any outstanding balance due.

_____ *TEACHING FACILITY*: I understand that RVHC is an internal medicine teaching facility. The interns, residents, medical students and other professional students will participate in my health care under the supervision of Board Certified attending physicians. I understand that all of my insurance claims will be submitted under the attending Physicians supervising my health care.

_____ *LABORATORY SERVICES*: I understand that RVHC uses an outside reference laboratory for all laboratory tests performed. RVHC will provide my insurance information to the reference laboratory; however, I will be fully responsible for any laboratory charges incurred payable directly to the reference laboratory.

_____ *CLINIC HOURS:* The Health Center is open Monday-Friday, 8am-5pm. We are closed for lunch from 12pm-1pm and our phone hours are 8am-4:30pm.

_____ HOLIDAY CLOSURES: Rocky Vista Health Centers is CLOSED ON ALL school observed holidays, including the following: Martin Luther King, Jr. day, President's Day, Memorial Day, Independence Day, Labor Day. In addition, we are closed for Thanksgiving break Thursday and Friday and winter break, Christmas even through January 1st (this may vary depending on when the holiday falls). Our on call service will be available.

_____ *APPOINTMENTS:* We do not accept walk in patients. Please call the office for any appointments and we will do our best to accommodate your needs. If our schedule is full, we will advise you accordingly and may recommend an urgent care facility.

_____ *ARRIVAL TIME:* Please arrive 15 minutes prior to your scheduled appointment to allow for the check in process. If you are late for your appointment, you may be asked to reschedule.

_____ *CANCELLATIONS:* Please be sure to provide our office a 24 hour notice of cancellation for all appointments to allow other patients the opportunity to be seen. Chronic last minute cancellations or non-cancelled missed appointments may result in discharge from our practice.

_____ AFTER HOURS: We provide after hours EMERGENCY on call services. This service is for EMERGENCIES ONLY!! Any call made after hours that is not an emergency may be subject to a fee.

_____ *MEDICATIONS:* We do not refill ANY medications after hours. Always contact your pharmacy first for any refill request. Controlled substance refills ALWAYS require an in office appointment, NO EXCEPTIONS!!! Please allow 3-5 business days for the processing of all medication refill requests. All controlled substances are reported to the Colorado drug monitoring program.

_____ MEDICAL RECORDS REQUESTS: We recommend you register for the patient portal to have access to your secure medical information. Any medical records requests will be processed within 10 business days from the date of receipt and are subject to copying fees.

_____ *FORMS*: Please allow 5 business days for the completing of any form. Most forms require an in office visit for accurate completion.

_____ _____

Signature Date