Rocky Vista Health Center

720-875-2880 Fax-720-875-2877
8401 S Chambers Rd, Parker, CO 80134

REGISTRATION

Patient Information (Please Sign and return to Receptionist)

Last Name	First Name	Middle Initial	Date of Birth
Address	City	State	Zip
Home Phone / Day Phone	Cell Phone / E-mail		Driver's License #
Preferred Language	Race / Ethnicity		Social Security #

Gender: ❑ Male ❑ Female RVU Student: ❑ Yes ❑ No
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner
Preferred Method of Contact: ❑ Mail ❑ Phone ❑ Cell Phone ❑ Patient Portal (Athena Health)

Responsible Party (Parent or legal guardian who resides with patient)

Last Name	First Name	Middle Initial	Date of Birth
Address	City	State	Zip
Home Phone / Day Phone	Cell Phone / E-mail		Driver's License #

Gender: ❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Life Partner
Relationship to patient:

Emergency Contact (If different from responsible party)

Last Name	**First Name**	**Middle Initial**	Date of Birth
Address	City	State	Zip
Home Phone / Day Phone	**Cell Phone** / E-mail		

Relationship to patient:

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the staff of **Rocky Vista Health Center** which they may deem advisable. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical service for myself and my dependents regardless of insurance coverage, excluding only authorized covered services provided under a valid prepaid HMO contract.

I furthermore agree to pay legal interest, collection expense, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Rocky Vista Health Center to release information requested by insurance company and/or its representative.

_____ I fully understand this agreement and consent will continue until canceled by me in writing.
Initial

SIGNATURE:_____ **DATE:**_____

NAME (Please print):_____ **RELATIONSHIP:**_____

Pharmacy Information

Preferred Pharmacy	Secondary Pharmacy
Name	Name
Address	Address
Phone	Phone
Fax	Fax

Advance Directives

❑ None ❑ Do Not Resuscitate ❑ Durable Power of Attorney ❑ Living Will ❑ HC Proxy
Date Reviewed:

Medications

❑ I do not take any medications.

List all medications you take with dosages.
Include prescriptions, nonprescriptions, over the counter, vitamins, and herbal supplements.

Medication Name	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Medication and Food Allergies

❑ No Known Allergies

List all known allergies (DRUGS, FOOD, ANIMALS, ETC):

1.
2.
3.
4.
5.
6.
7.
8.

Medical History

Please check if you have ever experienced any of the following conditions, and year of onset.

Condition	Year	Condition	Year
❑ None		❑ Gallbladder disease	
❑ Allergies		❑ GERD (Reflux)	
❑ Anemia		❑ Hepatitis C	
❑ Angina		❑ Hyperlipidemia	
❑ Anxiety		❑ Hypertension	
❑ Arthritis		❑ Irritable bowel disease	
❑ Asthma		❑ Liver disease	

Medical History (continued)

Condition	Year	Condition	Year
❑ 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	
❑ COPD (Emphysema)		❑ Seizure disorder	
❑ Crohn's disease		❑ Thyroid disease	
❑ Depression		❑ Other	
❑ Diabetes		❑ Other	

Surgical History

Please check if you have had any of the following procedures, and provide year procedure was done.

Surgical procedure	Year	Surgical procedure	Year
❑ None		**Men Only**	
❑ Angioplasty		❑ Prostate Biopsy	
❑ Angioplasty w/ stent		❑ TURP (Trans-Urethral Resection of the Prostate)	
❑ Appendectomy			
❑ Arthroscopy knee		❑ Vasectomy	
❑ Back surgery		❑	
❑ CABG (heart bypass)		❑	
❑ Carpal tunnel release			
❑ Cataract extraction		**Women Only**	
❑ Cholecystectomy		❑ Augmentation mammoplasty	
❑ Colectomy		❑ Bilateral tubal ligation	
❑ Colostomy		❑ Breast biopsy	
❑ Gastric bypass		❑ Cesarean section	
❑ Hernia repair		❑ D and C	
❑ Hip replacement		❑ Hysterectomy	
❑ Knee replacement		❑ Mastectomy	
❑ LASIK		❑ Myomectomy	
❑ Liver biopsy		❑ Reduction mammoplasty	
❑ Pacemaker		❑ TAH/BSO	
❑ Small bowel resection		❑ Vaginal hysterectomy	
❑ Thyroidectomy		❑	
❑ Tonsillectomy		❑	

Health Maintenance

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

Exams	Date	Exams	Date
❑ None		❑ GYN exam	
❑ Breast Exam		❑ Influenza Vaccine	
❑ Cardiac Stress Test		❑ Lipid Panel	
❑ Colonoscopy		❑ Mammogram	
❑ DEXA Scan		❑ PAP Test	
❑ Echocardiogram		❑ Physical Exam	
❑ EKG		❑ Pneumococal Vaccine	
❑ Eye Exam		❑ Pulmonary Function Test	
❑ FOBT (stool card for hidden blood)		❑ Sigmoidoscopy	
❑ Foot Exam		❑ Tetanus Vaccine	

Family History

Please check if any family member has had any of the following conditions. ❑ Adopted							
Diagnosis	**Mother**	**Father**	**Sister**	**Brother**	**Other**	**Other**	**Other**
Alcoholism							
Allergies							
Alzheimer's disease							
Asthma							
Blood disease							
CAD (heart attack)							
Cancer/ Indicate Type:							
CVA (Stroke)							
Depression							
Developmental delay							
Diabetes							
Eczema							
Hearing deficiency							
Hyperlipidemia (high cholesterol)							
Hypertension (high blood pressure)							
Irritable bowel disease							
Learning disability							
Mental illness							
Tuberculosis							
Obesity							
Osteoarthritis							
Osteoporosis							
PVD							
Renal disease							
Other:							

Advance Directives

Do you have children? ❑Yes ❑No	How Many?	Female/s:	Males/s:

Tobacco Use:	❑Yes ❑No ❑Former, Year Quit:_____ Type: ❑Chewing ❑Pipe ❑Cigar ❑Cigarette ❑Smokeless,Brand:_____ Frequency: ❑Daily ❑Some days ❑Not sure	
Alcohol Use:	❑Never ❑Yes ❑No ❑Former/Year Quit:_____ Type: ❑Beer ❑Liquor ❑Wine ❑Other:_____ Frequency: ❑Daily ❑Some days ❑Not sure	
Exercise/Activity	Level: ❑Moderate ❑Sedentary ❑Vigorous Frequency: ❑Daily ❑Some days ❑Not sure	**Sleep Pattern:** Changes: ❑Yes ❑No
Caffeine Use:	❑Never ❑Yes ❑No ❑Former/Year Quit: Type: ❑Chocolate ❑Coffee ❑Soda ❑Tablets ❑Tea ❑Other:_____ Frequency: ❑Daily ❑Some days ❑Not sure	

Patient Name:_____

Rocky Vista Health Center

Statement of Financial Responsibility

Private Insurance Authorization-Assignment of Benefits: I hereby authorize and direct payment of my medical benefits to Rocky Vista Health Center. I authorize the physicians to release any information regarding services furnished to me by the physicians to third party payers and/or health practitioners. In the event my health plan determines services to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered to me, including any fees for collection services if needed.
_____**(Initials)**

Private I: I hereby assume responsibility to pay the costs of all services provide me by Rocky Vista Health Center and its physicians.
_____**(Initials)**

Authorization of Payments: I understand that Rocky Vista Health Center will assist me in submitting my claim to the insurance carrier. I hereby authorize Payment directly to Rocky Vista Health Center and its physicians. I understand I am financially responsible for my health insurance deductibles, co-pays and non-covered services.
_____**(Initials)**

Laboratory Bills: I understand that an outside reference laboratory will bill me directly for all laboratory tests performed. Rocky Vista Health Center will provide my insurance information to the reference laboratory and I will be fully responsible for payment of any fees not covered by my insurance.
_____**(Initials)**

Teaching Facility: Rocky Vista Health Center is a teaching facility. I understand that Internal Medicine Residents under the supervision of a Board Certified attending physician, may render my medical care jointly. I authorize the admittance of qualified observers, including medical students during my consultation and/or examination.
_____**(Initials)**

Medicare and Medicare Supplemental Plan Lifetime Signature on File: I request that payment of authorized Medicare and Medicare Supplemental plan benefits be made to Rocky Vista Health Center. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents and any Medicare Supplemental plan any information needed to determine the benefits payable for related services.
_____**(Initials)**

_____ _____

Signature **Date**

Patient Name:_____

Rocky Vista Health Center
Health Center Policies

Welcome to Rocky Vista Health Center. Our physicians and staff are here to assist you with your medical needs and provide the best care possible. We have several policies we would like to make you aware of. If you have any questions or concerns, please ask a member of the staff and we will be happy to answer any questions.

Emergency: If you have a true emergency, please call 911 or go to the nearest emergency room.
Clinic Hours: The Health Center is open Monday through Friday from 8am to 5pm excluding lunch from 12pm to 1pm.
Same Day Appointments: Walk ins are discouraged. Please call the office and we will attempt to accommodate your needs. However, you may need to visit an Urgent Care center if our schedule is completely full.
Physician's Schedules: Your physician may not be in the clinic every day. If you need to see your regular physician, you will be required to schedule on the day he/she is in the clinic. If your visit can't wait, one of our other physicians can provide you with the care you need with full access to your medical records and history.
After Hours: When the Health Center is closed we will have an on-call physician available. Call the main Health Center number and our answering service will take your call and direct you to the on-call physician if necessary. No medication refills will be given and no appointments will be scheduled after hours.
Insurance Information: Always bring your picture ID and insurance information to your appointments.
Medications: Always bring a list of your current medications to your appointments.
Arrival Time: Please be on-time for your appointments. Our clinic is busy and late arrivals disrupts the schedule. If you are more that seven (7) minutes late, you may be asked to reschedule.
Cancellation Policy: We have a 24 hour cancellation policy. Patients who miss their appointments or fail to cancel without a 24 hour notice may be charged a fifty dollar (50) cancellation fee. Medicaid prohibits charging a cancellation fee, but the clinic can delay rescheduling the patient for up to 30 days.
Payments: All payments (co-pays), deductibles and outstanding balances) are due and payable the day of your appointment.
Controlled Substances: We do not give refills for controlled substances (narcotic pain medication, anxiety and benzodiazepines etc.) over the phone. You must schedule a visit with your physician for such refills.
Records Requests: There is a forty-eight (48) hour turnaround on all medical records requests and fourteen (14) days for physician forms needing to be filled out.
Medication Refills: Please contact your local pharmacy at least five (5) days in advance of your needed refill. Do not call the Health Center as this may slow down the process. It is YOUR RESPONSIBILITY to make sure you have enough of your medications or approved refills when you leave the clinic. **CALLING IN AT THE LAST MINUTE REQUESTING A NEW PRESCRIPTION IS UNACCEPTABLE** especially for controlled substances. Controlled substances refills CANNOT be called in to a pharmacy. You must have an office visit and a written prescription. This is a state law/regulation which cannot be overridden.

_____ _____

(Parent's Signature) **(Date)**

_____ _____

Signature **Date**

Patient Name:_____

Rocky Vista Health Center

Patient's Rights and Responsibilities

Rocky Vista Health Center is staffed and patient care is provided by licensed Colorado physicians and other healthcare professionals dedicated to providing you with the best healthcare diagnosis and treatment available .Our physicians and staff are here to care for your medical needs and assist you wherever possible.

As a patient of Health Center, you have the following rights:

- To know the identity, professional status and experience of those with whom I interact.
- Make choices regarding my healthcare professional.
- Receive considerate, professional, respectful and private care.
- Expect effective communication that maintains confidentiality.
- Expect that every professional with whom I interact to fully comply with HIPPA privacy regulations and other laws or regulations pertaining to the delivery of healthcare services.
- Receive complete and understandable information regarding my diagnosis, options, risks and alternatives.
- Refuse or withdraw my consent at any time and discontinue any treatment, drug or procdure.
- Be provided timely access to my medical records for review.
- Expect an explanation of all billing charges and procedures, and expect a timely resolution of all billing concerns.
- Register a complaint or concern regarding my 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 limitations on your ability to exercise certain rights listed above.

As a patient of Health Center, you have the following responsibilities:

- To provide complete and accurate health information.
- To provide complete and accurate financial and billing information.
- To ask questions that are significant for your healthcare.
- To participate with your physician in the development and implementation of your plan of care.
- To take responsibility for refusing treatment, withdrawing consent or failing to follow a plan of care.
- To report any worsening of your condition or unexpected reactions to medications promptly.
- To keep appointments and to follow that Health Center's cancellation policy.

I have read and understand the foregoing and agree to adhere to the Health Center's policies.

_____ _____

Signature **Date**

Patient Name:_____

Contact Information

Rocky Vista Health Center is staffed may need to contact you about test results, appointments, referrals or billing/insurance information. 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 for leaving medical care messages.

Unless we have permission to do so:

- **We will NOT leave messages with anyone except the patient or legal guardian**
- **We will NOT leave messages on voicemail or answering machines**
- **We will NOT send emails or 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 regarding my medical care/account information to:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I give Rocky Vista Health Center permission to contact me in the following manner (this may include detailed information such as appointment dates and times and lab/imaging results.)
Please check all that apply:

Home Telephone Number:_____

- ❑ **OK to leave message with detailed information**
- ❑ **OK to leave message with other family members**
- ❑ **DO NOT leave a message**

Work Telephone Number:_____

- ❑ **OK to leave message with detailed information**
- ❑ **DO NOT leave message**

Cell Telephone Number:_____

- ❑ **OK to leave message with detailed information**
- ❑ **OK to leave message with person answering**
- ❑ **DO NOT leave a message**

_____ _____

Signature **Date**