131 S. Main St.#101 Pueblo, CO. 81003 **P:** 719.924.9398 **F:** 719.924.9593

◇Jill Olvey FNP-C ◇Ashley Kirby FNP-C ◇Michelle Hartke FNP-C ◇Pam Isley ANP-C ◇Karla Richardson-Trujillo NP-C

NEW PATIENT REGISTRATION FORM:

Last Name:	First Name:	MI:	Date of Birth:
Address:	City:	State:	Zip:
SSN:	Age:	Cell #:	Alt #:
Gender:	Employer:	Pharmacy:	

Email (to access our patient portal, receive lab/imaging results, and contact your provider directly):

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Life Partner

Race/Ethnicity:

INSURANCE INFORMATION:

PRIMARY INSURANCE:	Member ID #:	Group #:
Guarantor's (Responsible Party) Last Name:	First Name:	
Date of Birth:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Parent ☐Other	
SECONDARY INSURANCE:	Member ID #:	Group #:
Guarantor's (Responsible Party) Last Name:	First Name:	
Date of Birth:	Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Parent ☐Other	

EMERGENCY CONTACT INFORMATION:

Last Name:	First Name:	Relationship:
Home #:	Cell #:	Alt #:

PATIENT STATEMENT:

I hereby grant my permission for Rocky Mountain Primary Care Clinic and its employees to provide medical care for me. I understand that I am financially responsible for my medical care whether or not paid by insurance and I hereby authorize Rocky Mountain Primary Care Clinic to release all information necessary for my treatment and to bill and receive payment. I acknowledge that I have received a copy of the Rocky Mountain Primary Care Clinic's Privacy Practices. I understand that my PDMP will be pulled and reviewed prior to being scheduled for an appointment or placed on a waiting list.

Signature **Date**

	NEW PATIENT HISTORY: Please check any conditions that you have experienced past or present.	
	? ADHD	? Headache (Specify) ________________________
	? Alcoholism	? Heart Attack (MI)
	? Allergies	? Heart Disease
	? Anemia	? Hepatitis/Liver Disease (Specify) ________________________
	? Anxiety	? Hiatal Hernia
	? Arrhythmia (Irregular Heart Beat)	? High Blood Pressure
	? Arthritis	? High Cholesterol
	? Asthma	? HIV
	? Atrial Fibrillation	? Incontinence (Specify) Bladder or Bowel
	? Benign Prostatic Hypertrophy	? Irritable Bowel Syndrome (IBS)
	? Bipolar Disorder	? Kidney Disease
	? Bleeding Issues	? Kidney Stones
	? Cancer (Specify) ____________________________________	? Learning Disorder (Specify) ___________________________
	? Chest Pain	? Lupus
	? Chronic Pain (Specify) ______________________________	? Multiple Sclerosis
	? COPD/Emphysema	? Neuropathy
	? Dementia	? Obesity
	? Depression	? Osteoarthritis
	? Diabetes (Specify) Type 1 or Type 2	? Osteopenia/Osteoporosis
	? Diverticulitis	? Parkinson's Disease
	? DVT (Blood Clot)	? Peripheral Vascular Disease
	? Edema	? Psoriasis
	? Gastroparesis	? Pulmonary Embolism (PE)
	? GERD (Acid Reflux)	? Rheumatoid Arthritis
	? Glaucoma/Macular Degeneration	? Seizure Disorder
	? Other (Specify) ______________________________________	? Sleep Apnea
	? STD (Specify) ____	? Stroke
	? Visual Disorder (Specify) ______________________________	? Thyroid Disorder (Specify) ______________________________

MEDICATION & FOOD ALLERGIES: List all known allergies (drugs, food, animals) and reactions. ☐ **No Known Allergies**	
Allergy:	**Reaction:**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

SURGICAL HISTORY: List all prior surgeries, approximate dates performed, and the doctor if known. ☐ **No Prior Surgeries**		
Surgery:	**Doctor:**	**Date:**
1.	1.	1.
2.	2.	2.

3.	3.	3.
4.	4.	4.

MEDICATIONS: List **all** medications you take, prescription and over the counter/herbal supplements/vitamins, the dosage, frequency, and reason for taking the medication. ☐ **I Do Not Take Any Medications**

Medication:	Dose:	Frequency:	Reason for Medication:
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.
7.	7.	7.	7.
8.	8.	8.	8.
9.	9.	9.	9.
10.	10.	10.	10.
11.	11.	11.	11.
12.	12.	12.	12.
13.	13.	13.	13.
14.	14.	14.	14.

PREVENTATIVE HEALTH: Check if you have received the following and the date of the most recent exam.

Exam:	Result:	Date:
☐ Cardiac Stress Test	☐ Normal ☐Abnormal	
☐ Colonoscopy	☐ Normal ☐Abnormal	
☐ DEXA Scan	☐ Normal ☐Abnormal	
☐ Echocardiogram	☐ Normal ☐Abnormal	
☐ EKG	☐ Normal ☐Abnormal	
☐ Eye Exam	☐ Normal ☐Abnormal	
☐ Diabetic Foot Exam	☐ Normal ☐Abnormal	
☐ Influenza Vaccine		
☐ Mammogram	☐ Normal ☐Abnormal	
☐ PAP Test	☐ Normal ☐Abnormal	
☐ Physical Exam (Annual)		
☐ Pneumococcal Vaccine		
☐ Pulmonary Function Test	☐ Normal ☐Abnormal	
☐ Tetanus Vaccine		

FAMILY HISTORY: Check if any family member(s) has had any of the following conditions.

Diagnosis:	Mother	Father	Sister	Brother	Other (Specify)
Alcoholism	☐	☐	☐	☐	☐ ________________
Anxiety	☐	☐	☐	☐	☐ ________________
Arrhythmia	☐	☐	☐	☐	☐ ________________
Asthma	☐	☐	☐	☐	☐ ________________

Bipolar Disorder	☐	☐	☐	☐	☐ ________________
Bleeding Disorder	☐	☐	☐	☐	☐ ________________

FAMILY HISTORY (cont'd): Check if any family member(s) has had any of the following conditions.					
Diagnosis:	Mother	Father	Sister	Brother	Other (Specify)
Cancer – Type:____________	☐	☐	☐	☐	☐ ________________
Dementia	☐	☐	☐	☐	☐ ________________
Depression	☐	☐	☐	☐	☐ ________________
Diabetes – Type: 1 or 2	☐	☐	☐	☐	☐ ________________
Heart Disease/Heart Attack	☐	☐	☐	☐	☐ ________________
High Blood Pressure	☐	☐	☐	☐	☐ ________________
High Cholesterol	☐	☐	☐	☐	☐ ________________
Kidney Disease	☐	☐	☐	☐	☐ ________________
Lupus/Rheumatoid Arthritis	☐	☐	☐	☐	☐ ________________
Obesity	☐	☐	☐	☐	☐ ________________
Osteoarthritis	☐	☐	☐	☐	☐ ________________
Osteoporosis	☐	☐	☐	☐	☐ ________________
Sleep Apnea	☐	☐	☐	☐	☐ ________________
Stroke	☐	☐	☐	☐	☐ ________________
Thyroid Disorders	☐	☐	☐	☐	☐ ________________
Other:_________________	☐	☐	☐	☐	☐ ________________

SOCIAL HISTORY (Adult patient):

Occupation:		Employer:		
Are you Pregnant? ☐ Yes ☐ No	Do you have Children? ☐ Yes ☐ No	How Many?	Female(s)	Male(s)

Tobacco Use ☐ No ☐ Yes	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:__________	☐ Chewing ☐ Cigarette ☐ Cigar ☐ Vape/E-Cigarette
Alcohol Use ☐ No ☐ Yes	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:__________	☐ Beer ☐ Wine ☐ Liquor ☐ Other:
Caffeine Use ☐ No ☐ Yes	☐ Daily ☐ Weekly ☐ Less ☐ Former/Year Quit:__________	☐ Chocolate ☐ Soda ☐ Tea ☐ Tablet ☐ Coffee

SOCIAL HISTORY (Pediatric patient):

Patient Resides With:	Primary	☐ Mother	☐ Father	☐ Both Parents	☐ Other
	Secondary	☐ Mother	☐ Father	☐ Other	

Mother's Occupation:	Father's Occupation:
Parents Relationship: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other	Childcare: ☐ Mother ☐ Grandparent(s) ☐ Father ☐ Nanny ☐ Sibling ☐ Daycare
Immunizations Up To Date? ☐ Yes ☐ No	Full Term Delivery ☐ Yes ☐ No

Pregnancy Complications? (Specify):

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Office Policies

Patient Name(PRINT):____**DOB:** ____________________

Welcome to Rocky Mountain Primary Care Clinic - a Nurse Practitioner owned and operated clinic. Striving to serve as your patient-centered medical home we encourage you to be an active participant in your healthcare. ***You*** are the most important member of your healthcare team and we look forward to working with you to ensure you get the quality care that you deserve. In order to provide quality care, we ask that you that your review and acknowledge our general office policies as outlined below:

1. **Appointments** – A big part of being healthy is actively participating in your own health care and we are here to help you make decisions regarding your wellbeing. In order to help you make healthcare decisions and evaluate your condition, it is important to attend your scheduled appointments. If cancellation or rescheduling is necessary, please do so with at least 24-hours advance notice. **Patients who fail to cancel appointments prior to 24 hours, arrive more than 10 minutes late causing the appointment to be rescheduled, or "no call/no show" 3 times may be discharged from the practice at the discretion of the staff.** Our nurse practitioner's schedules fill up fast so please make sure to make a follow up appointment at checkout. ◇**Initial** __________
2. **Medications and Refills** – Prescriptions that need to be refilled every four (4) weeks will only be provided during **regularly scheduled appointments** and **not** during acute appointments for other medical issues. **If you do not keep your appointment you will not receive a refill until that appointment is rescheduled and you attend that appointment – this is at the discretion of your healthcare provider.** If you are requesting refills please note that the refill process can take up to seven (7) business days. It is recommended that when refills are required you call your pharmacy at least one (1) week before the medication is needed. This will allow time for the pharmacy to notify us of the refill request and for us to refill your prescription. In the event that a **prior authorization is needed for your medication, this process can take up to seven (7) business days.** No refills will be made by telephone or outside of regular business hours. ◇**Initial** __________
3. **Urgent/Acute Visits** – Rocky Mountain Primary Care Clinic balances between regular follow up visits and emergency or acute visits. In efforts to help the continuity of your care please call our office for urgent care needs prior to going to the emergency room or hospital. If you are experiencing a life threatening emergency please proceed to the ER immediately. Appointments are set aside daily for acute visits. We will do our best to schedule you with your primary care provider, however, in cases of emergency you may be asked to see a covering provider. Chronic medication refills, regular evaluations, paperwork, etc. will **not** be addressed during these visits.
◇**Initial** __________

4. **Co-Payments** – Payments are expected at the time of your visit. If you do not have your co-payment at the time of your visit you may be asked to reschedule your appointment. This will constitute as a no call/no show to your appointment.◇**Initial ___________**

5. **Continuity of Care** – We feel strongly that continuity of care is best served when you see your primary care provider. It is requested that you do not "bounce" between providers in this office or other offices. If you feel you do not want to be seen by one of our providers you may be asked to find a provider outside of this office.
◇**Initial ___________**

6. **Being Prepared** – Come to each appointment prepared. Bring a complete list of current medications, vitamins, supplements, etc. to each visit. If you were asked to complete tests, please do so prior to your visit. Write down questions and concerns prior to your visit. Being prepared will help to increase the quality of your appointment.
◇**Initial ___________**

7. **Calling Our Office** – Do not hesitate to call our office if you have questions regarding your care, medications, or medical condition. Our nurse practitioners and staff will do our best to respond in a timely manner. **Use the voice mail system that is checked on a routine basis throughout the day and each message will be returned in the order of priority.** If you do not get a return call within 3 business days please call and speak with our office manager. If you have a medical emergency *call 911* or go to the nearest emergency room. ◇**Initial ___________**

8. **Demographic Information** – It is your responsibility to update your phone number and address at each appointment. We rely on accurate contact information to notify you of referral/imaging appointments, lab/imaging results, follow up appointment confirmations, etc. In order to help you and to care for your medical conditions, we often write orders for labs, schedule imaging, schedule specialist consults, etc. Failure to attend these appointments and/or discussing your non-attendance with your provider will be grounds for discharge from RMPCC. If you do not hear from a specialist, physical therapy provider, imaging facility, etc. within 7-10 business days it is your responsibility to contact our office so that we can assist you in getting arrangements made. ◇**Initial ___________**

9. **Discharge** – In the instance that you are discharged from this office; you may be seen for 45 days on an emergency basis only. During this time, controlled substances will not be filled. You will be given a list of other offices in town accepting new patients and you are responsible for contacting these offices. Your records will be transferred to the office of your choosing once a written consent is signed and received by this office. If you decide to no longer be a patient at RMPCC you will be given a written letter that you must sign and date. You will no longer be seen at this office under any circumstances and your prescriptions will no longer be filled. ◇**Initial ___________**

10. **Respect** – Mutual respect between office staff and patients is **mandatory**. Please notify the office management immediately if you feel that the office staff is not meeting your needs. If mutual respect is not maintained this will be grounds for discharge from the office. **Disrespect and/or abuse towards the staff of *any* kind will not be tolerated and is grounds for discharge.** ◇**Initial ___________**

____

Signature **Date**

131 S. Main St. Pueblo, CO. 81003 P: 719.924.9398 F: 719.924.9593

HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Rocky Mountain Primary Care Clinic to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Rocky Mountain Primary Care Clinic

I have also been informed of, and given the right to review and secure of a copy of the Rocky Mountain Primary Care Clinic Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Rocky Mountain Primary Care reserves the right to change the terms of this notice at any time and that I may contact Rocky Mountain Primary Care Clinic at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

Name (PRINT): ____ Date of Birth:_________________________

Signature: ____ Date:________________________________

1. I wish to be contacted in the following manner: **Be sure to fill in contact phone numbers** and **check whether we can leave a DETAILED message or JUST a call back number**

☐ **Primary #** _______________________________
- ☐ Leave message with **detailed** info
- ☐ Leave message with a **call back number only**

☐ **Work #** _____________________________
- ☐ Leave message with **detailed** info
- ☐ Leave message with a **call back number only**

☐ **Alternate #** ____________________________
- ☐ Leave message with **detailed** info
- ☐ Leave message with a **call back number only**

☐ **Written Communication**
- ☐ can send letter with **detailed** information
- ☐ Okay to fax to this #:__________________

2. **PLEASE INDICATE WHO WE CAN SPEAK TO REGARDING YOUR MEDICAL INFORMATION:**

(check all that apply)

☐ Patient only

☐ Significant Other: Name:_____________________________________ Phone:______________________________

☐ Parent(s): Name:_____________________________________ Phone:______________________________

☐ Relative: Name:_____________________________________ Phone:______________________________

☐ Other: Name:_____________________________________ Phone:______________________________

☐ Other: Name:_____________________________________ Phone:______________________________

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Financial Policies

Patient Name(PRINT):______________________________ **DOB:** ____________________

Thank you for choosing Rocky Mountain Primary Care, we welcome you to our office. We are better able to concentrate on the practice of medicine and provide quality care by having our financial policies understood by our patients, thus avoiding confusion or misunderstandings.

1. **Insurance** – Filing insurance claims are a courtesy extended to our patients and is not a guarantee of payment. We will bill insurance claims with a maximum of two (2) insurance carriers per patient. It is important to emphasize that your insurance is a contract between you and the insurance carrier. Insurance plans and contracts change constantly. <u>It is your responsibility to contact your insurance company and verify your benefits and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we are not paid by your insurance carrier.</u> ◇**Initial**__________
2. **Co-pays and Deductibles** – All copays are due at the time services are rendered. Deductibles are due upon receipt of an explanation of benefits from your insurance carrier. Failure on our part to collect copayments and deductibles from patients can be considered fraud and we could be subject to fines or other consequences. Please be sure to pay all co-pays and deductibles as stated above to avoid an interruption of your care. ◇**Initial**__________
3. **Non-covered Services** – Please be aware that some – and perhaps all – of the services you receive may be a non covered benefit. You must pay for these services at the time services are rendered. Please note; a check of eligibility is not a guarantee of payment on your behalf from your insurance carrier. ◇**Initial**__________
4. **Coverage Changes** – It is your responsibility to notify our office immediately upon changes with your insurance carrier. Failure to do so will result in Rocky Mountain Primary Care Clinic billing you for services rendered.
   ◇**Initial**__________
5. **Nonpayment** – All payments are due immediately and in full. Failure to do so within 90 days will result in your account being sent to an outside collection agency. ◇**Initial** __________

Our Practice is committed to providing you with the best treatment possible. *We are willing to work with any patient requesting a financial payment plan.* By signing below you are acknowledging that you have read and understand all terms that are outlined in this policy. Should you have any questions or concerns, please feel free to address them with us.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICIES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. A PHOTOCOPY OR SCANNED COPY OF THE ASSIGNMENT RELEASE IS AS VALID AND EFFECTIVE AS THE ORIGINAL.

____

Signature Date

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AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	DOB:	Last 4 of Social Security Number:
Address:	City, State, ZIP:	Phone Number:

I hereby authorize the facility listed below to disclose/ release the Protected Health Information specified in this request to the organization, facility, or person named below.

Release **FROM**:	Release **TO**:
NAME OF FACILITY/ORGANIZATION/PERSON:	NAME OF FACILITY/ORGANIZATION/PERSON:
ADDRESS:	ADDRESS:
PHONE/FAX:	PHONE/FAX:

PURPOSE OF DISCLOSURE:

☐ Continuation of Medical Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Disability

☐ Other (Specify):____

INFORMATION TO BE DISCLOSED:

☐ Entire Medical Record ☐ Office Notes / Treatment Plan ☐ Laboratory Results

☐ Imaging Results ☐ Billing Records ☐ Other (Specify):____________________

DATES OF TREATMENT:

☐ Most Recent Year ☐ All Dates ☐ Other (Specify):___________________________

IF ANY OF THE FOLLOWING INFORMATION IS TO BE DISCLOSED, CHECK *ALL* THAT APPLY BELOW:

☐ Alcohol/Drug Addiction Treatment ☐ Psychotherapy Notes ONLY

☐ Sexually Transmitted Disease Treatment ☐ Mental Health

☐ HIV/AIDS – Related Treatment

- I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol abuse/treatment.
- I understand I have the right to revoke this authorization in writing.
- I understand the revocation will not apply to information that has already been released in response to this authorization.
- I understand the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. To revoke an authorization I will write a letter to the facility/Provider.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under the Privacy laws.
- I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
- I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment) However my signature is required to receive health care when the purpose is to create health information for a third party.
- This authorization will expire 1 year from the date signed unless other date specified here:_______________. A copy or facsimile of this authorization shall be counted true and valid as the original.

____

Signature of Patient/Legal Representative **Date**

____

Relationship to Patient (IF SIGNED BY LEGAL REPRESENTATIVE)

PRINTED Name of individual (IF SIGNED BY LEGAL REPRESENTATIVE)