Rocky Ford Family Health Center, LLC
New Child Patient Registration Information

Name (First, Middle, Last): _____

DOB: _____ **Gender (Circle): Male or Female** **SSN:** _____-_____-_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Daytime Phone: _____ **Evening Phone:** _____

Race: _____ **Ethnicity:** _____ **Preferred Language:** _____

Employer's Name: _____ **Phone Number:** _____

Guarantor Information *(person responsible for payment of your account if somebody other than self):*

Name (First, Middle, Last): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Daytime Phone: _____ **Evening Phone:** _____

Employer's Name: _____

Employer Address & Phone Number: _____

Insurance Info:

Primary Insurance: _____
Member ID: _____ **Policy Group ID:** _____ **Effective Date:** _____

Are you the policy holder? Yes ____ No ____ *(If no is checked, please list the name of the policy holder):*
_____

Secondary Insurance: _____

Member ID: _____ **Policy Group ID:** _____ **Effective Date:** _____

Are you the policy holder? Yes ____ No ____ *(If no is checked, please list the name of the policy holder):*
_____

Please present a copy of your insurance card(s) along with a photo ID.

Prescription Drug Plan: _____

Preferred Pharmacy: _____

By signing your name, you are giving your consent for our office staff to leave voicemails on the phone number you provided for appointment reminders and other reasons that may pertain to your medical record:

Signature: _____ **Date:** _____

Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed and how you can get access to this information.

Please read this carefully.

The Health Insurance Potability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other patient health information (PHI) is safeguarded. Whether we disclose of your medical records electronically, on paper, or orally, you have the right to understand and control how your health information is used. HIPAA provides penalties for anyone that may misuse PHI.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your PHI and how we may use or disclose your PHI.

Your PHI at Rocky Ford Family Health Center, LLC is on a secured electronic chart system. It can only be accessed by authorized staff members who have been assigned a log-in and password to our system.

Our staff will use/disclose your PHI for medical treatment and/or payments. (For example: Your PHI will be disclosed in referrals to specialist, sent to insurances for authorization on medications or testing such as a CT scan, MRI, US or X-rays, or to pay for services received in our office. Your PHI may also be used to correspond with another provider that is involved in your health care).

Your PHI may also be disclosed for internal business purposes, such as conducting quality assessments and improvement activities, auditing functions, cost management analysis and customer service. An example would be an internal quality assessment review.

Sometimes, we disclose PHI for purposes of research or statistic collection. In such cases, all of your personal identity information is removed.

Any other uses and disclosures will only occur with your written authorization. We are required to honor the most recent written authorization. You have the right to revoke any written authorization with a written request at any time.

The following is a list of your rights with respects to your PHI, which you can exercise by presenting a written request to the clinic's office manager.

- The right to request restrictions on certain uses and disclosures of PHI, including disclosures to family members, friends, or any other person identified by you. However, we are not required to agree to a requested restriction if doing so would not be in your best interest.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect or copy your PHI;
- The right to comment on your PHI;
- The right to receive an accounting of disclosures of PHI;
- The right to obtain a paper copy of this notice from us upon request.

Rocky Ford Family Health Center, LLC

Financial Policy

- All co-payments are due at the time of scheduled appointment. If you do not have your co-pay and you did not make arrangements before your appointment, you will be rescheduled. This appointment may result in a no-show.

- With most insurances, you are required to pay a deductible. If your deductible is not met at the time of your visit, you are required to pay for the visit in full. You will be required to pay your co-pay, or any other payment due on your account at the time of your visit or your appointment will be rescheduled.

- Understand that your insurance policy is a **contract between you and your insurance company**. As a service to you, we will file your insurance claim and have them pay our office directly. If your insurance company does not pay our office within 90 days, you will be responsible for payment. If we happen to receive a payment from your insurance after 90 days and you have already made a payment, your payment will be refunded to you.

- If we are not contracted with your insurance carrier, you will be responsible for payment at the time of service and you will be given a form to send into your insurer for a refund.

- Understand that ALL insurance plans are different and do NOT cover the same services. If your company does not cover a service that you received in our clinic, you will be held responsible for any remaining balance. Your payment will be due on receipt of statement from our office. If our office does not receive payment within 30 days, you will be turned over to a collection agency.

I have read and thoroughly understand the office's financial policy. I understand that these terms may be amended by the office at any time. I agree to be bound by the terms of this policy.

Rocky Ford Family Health Center, LLC
1014 Elm Ave
Rocky Ford, Co. 81067

Permission to disclose private medical information to specific relatives, close friends and/or other caregivers.

Patient Name (please print): _____ DOB: _____

I authorize Rocky Ford Family Health Center, LLC to disclose my private health information to the following persons listed below. I understand that I may change this list at any time by providing written notice. I understand that Rocky Ford Family Health Center, LLC is not required to agree to a requested restriction if it is not in my best interest.

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Print Name: _____ Phone Number (required):_____
Relationship to Patient: _____

Your signature indicating your agreement to allow disclosure of your private health information to the people listed on this form is required on Signature Sheet. This permission may be changed by providing a written notice to the clinic.

_____ _____

Signature of patient or guardian **Date**

Rocky Ford Family Health Center, LLC

Authorization to Release Medical Records/Information

Provider to provide records:

Name: _____
Phone #: _____
Fax #: _____

Patient Name: _____
DOB: _____
Social Security Number: __ __ __- __ __- __ __ __ __

Provider to receive records: **Rocky Ford Family Health Center, LLC**
1014 Elm Ave.
Rocky Ford, Co. 81067
P (719) 254-7421 F (719) 254-6966

I authorize the health care provider to release the information specified below to the organization, agency or individual named on the request. I specifically authorize the release of information regarding the following condition(s):

Initial Please:
_____ Drug Abuse if any
_____ Psychological or psychiatric conditions if any

Initial Please:
_____ Substance abuse if any
_____ AIDS/HIV if any

Release these records:	Initial Please:	Comments:
1. All records generated by this facility	_____	_____
2. Only some portions of records generated by this facility (Please Specify)	_____	_____

I understand that I may revoke this authorization at any time.

Patient Name (please print)
Name: _____
Address: _____
_____
Signature: _____
Date: _____

OR

Person authorized to sign for patient
Name: _____
Address: _____
_____
Signature: _____
Date: _____