Rocky Ford Family Health Center, LLC

Preferred Provider: Doug Miller, FNP-C _____

Heather Elliott, NP-C _____

Adult Patient Application/Registration Form

PATIENT INFORMATION

Name (First, Middle, Last): _____ Date of Birth: _____ SSN: _____

Address: _____ Apt #_____ City: _____ State: _____ Zip: _____

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

e-Mail address: _____ Register for access to patient portal? Yes___ No ___

Employer Name and Phone #: _____

Gender at Birth: Female _____ Male _____ Current Gender Identity: _____

Sexual Preference: _____ Marital Status: _____

Race #1: _____ Race #2: _____ Ethnicity: _____ Preferred Language: _____

INSURANCE/FINANCIAL INFORMATION

Insurance Policy #1: _____ Group #: _____ ID# : _____

Name of person who owns this policy: _____ Relationship to you: _____

Insurance Policy #2: _____ Group #: _____ ID# : _____

Name of person who owns this policy: _____ Relationship to you: _____

Who is financially responsible for your account? Name and phone #_____

Address: _____ City: _____ State: ___ Zip: _____

Prescription Drug Plan: _____ Preferred Pharmacy: _____

Payment method on file: If you allow us to store a credit or debit card number to use anytime you have a bill, you will receive an additional 5% off of your bills (Excludes labs and tests).

_____Yes, I authorize RFFHC to store my card # and use is anytime a patient amount is due.

My card # is: _____My expiration date is : _____ My CCV/CVC is: _____

Please provide copies of your photo ID and an insurance card.

PHARMACY INFORMATION

Prescription Drug Plan: _____ **Preferred Pharmacy:** _____

Address and phone number if not located in this area: _____

Name: _____ DOB: _____

SIGNATURE TO RECEIVE VOICEMAILS (OPTIONAL)

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: _____

PERSONAL MEDICAL HISTORY- check all that apply

Asthma/COPD _____	Heart Disease _____	Seizures _____	HIV _____
Cancer _____	Hepatitis _____	Stroke _____	Diabetes_____
Colon problems _____	High Blood Pressure _____	Thyroid Disease _____	
Depression/Anxiety _____	High Cholesterol _____		

Other Medical Issues (Please explain): _____

_____

Please list specialists you are seeing for the above problems: _____

Date and location of last colonoscopy: _____

Dentist: _____

List medical devices you use (CPAP, Oxygen, etc.): _____

Date of last colonoscopy:_____

WOMEN ONLY: Date of last menstrual period: _____ # of pregnancies: _____ # of live births: _____

Date of last pap:_____ Date of last mammogram:_____

VACCINES Received:

(If checked, please specify date and facility.)

_____Tdap _____

_____Pneumonia _____

_____Influenza(Flu)_____

_____Shingles_____

Do you smoke CIGARETTES? Yes_____ No_____

How many cigarettes per day? _____

How many years have you smoked? _____

ALLERGIES:

Please include MEDICATION, FOOD and/or ENVIRONMENTAL

_____

_____

_____

Do you smoke MARIJUANA? Yes_____ No_____

How often do you smoke? _____

How many years? _____

Name: _____ DOB: _____

Do you drink ALCOHOL? Yes_____ No_____

How many drinks per day? _____

How many drinks per week? _____

Do you use a VAPE pen? Yes_____ No_____

Do you use other TOBACCO-related products?

Cigars, pipes, chewing tobacco, etc. Yes____ No___

If yes, please specify_____

Do you use illegal drugs, or prescription drugs that have been prescribed to someone else? Yes_____ No_____

What do you take?_____ How often? _____

List all MEDICATIONS you are taking. Include prescription drugs, vitamins, supplements. Please include the dosage amounts and instructions.

_____

_____

_____

SURGICAL HISTORY-Please list all surgeries with approximate dates. _____

FAMILY MEDICAL HISTORY

Check all that apply. Indicate family member(s) relationship to you. If grandparent, aunt, uncle or cousin, note if family member is PATERNAL or MATERNAL.

_____Diabetes_____

_____Hypertension _____

_____Seizure_____

_____Blood Disorders_____

_____Autoimmune_____

_____Heart Disease _____

_____Osteoporosis_____

_____Stroke_____

_____Thyroid Disorder_____

_____Mental Illness

_____Cancer_____ Type of Cancer_____

Other Family Medical History not mentioned above: _____

_____

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: _____

Rocky Ford Family Health Center, LLC
1014 Elm Ave.
Rocky Ford, Co. 81067
(719) 254-7421

Colorado Regional Health Information Organization (COHRIO) Agreement

CORHIO is an organization that gives your healthcare team an opportunity to share, monitor and provide information about your health. This is done using HIPAA standards. Your information is only, shared, monitored or provided on a "need to know" basis.

To allow our office access to your health records and permission to share them using CORHIO, please complete this form. You have the right to opt of this agreement at any time. If you would like to do so, simply ask the receptionist for an opt out request form.

Patient Name: (First, Middle, Last):
Date of Birth (MM/DD/YYYY):
Gender (Male or Female):
Mailing Address:
City, State, Zip Code:
Contact Phone Number:
Alternative Phone Number:

Signature of patient or guardian: _____

Today's date: _____

Rocky Ford Family Health Center, LLC
Signature Sheet

Name (please print): _____ DOB: _____

PATIENT INFORMATION (reference pages 1&2)
My signature indicates that all information provided on the New Patient Information form is true and correct. I understand that it is my responsibility to report any change of address, phone number or insurance coverage to the clinic.

_____ _____
Signature of patient or guardian **Date**

HIPAA/PRIVACY PRACTICE ACKLOWEDGEMENT (reference pages 3&4)
I have received, read and understand the clinic's Notice of Privacy Practices

_____ _____
Signature of patient or guardian **Date**

PERMISSION TO DISCLOSE PRIVATE HEALTH INFORMATION (reference pages 3&4)
I have received, read and agree to the clinic's policy about disclosing health information.

_____ _____
Signature of patient or guardian **Date**

FINANCIAL POLICY (reference page 5)
I have read and thoroughly understand the clinic's financial policy and I agree to be bound by its terms. I also understand that such terms may be amended by the clinic at any time.

_____ _____
Signature of patient or guardian **Date**

NO SHOW POLICY (reference page 6)
I have received and read the no-show policy and I agree to be bound by its terms. I also understand that such terms may change at any time.

_____ _____
Signature of patient or guardian **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.