ROCKY MOUNTAIN FAMILY PRACTICE
Your family's favorite healthcare destination

2019 Patient Registration Form

Staff Initials____

PATIENT INFORMATION

NEW PATIENT: ☐

Last Name: _____ **First Name:** _____ **Middle Initial** _____

Mailing Address: _____

City: _____ **State:** _____

Zip Code_____

Date of Birth: _____/_____/_____

Gender: ☐Male ☐Female ☐Transgender

Race/Ethnicity: ☐Caucasian ☐Hispanic ☐Asian ☐African American ☐Native American ☐Other ☐Decline to give/Unknown

Primary Language:
☐English ☐Spanish ☐Other _____

Preferred Form of Contact:
☐ **E-Mail** ☐ **Cell Phone** ☐ **Home Phone** ☐ **Work Phone**
☐ **I would like access to the Patient Portal**

Social Security no.:	Home phone no.:	Cell phone no.:	E-Mail:
	( ) -	( ) -	

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is acknowledgment that you authorize Rocky Mountain Family Practice to:

☐ **Leave a detailed message on home phone machine** ☐ **Leave a detailed message on personal cell phone voicemail**
☐ **Transmit and Receive messages through our secure Patient Portal** ☐ **Text message**

RESPONSIBLE PARTY FOR BILLING PURPOSES

☐ **If SELF check here**

Last Name: _____ **First Name:** _____

Relationship to patient: _____ **Date of Birth:** _____

Home phone no.: _____ **Cell phone no.:** _____

Address (if different): _____

INSURANCE INFORMATION

☐ **Check here if you are SELF PAY**

Primary Insurance Carrier:

_____

Policy No. _____
Group No. _____

Primary Insured/Relationship to patient: ☐ **If SELF, check here**
Last Name: _____
First Name: _____
Relationship: _____
Insured's Date of Birth: _____

Secondary Insurance Carrier:

_____

Policy No. _____
Group No. _____

Primary Insured/Relationship to patient: ☐ **If SELF, check here**
Last Name: _____
First Name: _____
Relationship: _____
Insured's Date of Birth: _____

Lab Preference: ☐ **Quest Diagnostics** ☐ **LabCorp** ☐**Check here if unknown**

IN CASE OF EMERGENCY

Last Name: _____ **First Name:** _____	**Relationship to patient:** _____	**Cell phone no.:** ( ) -	**Home phone no.:** ( ) -
Last Name: _____ **First Name:** _____	**Relationship to patient:** _____	**Cell phone no.:** ( ) -	**Home phone no.:** ( ) -

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ALTERNATE CAREGIVER CONSENT

Except for life threatening emergencies, we are not able to treat your minor child unless he or she is accompanied to our office by a parent, legal guardian or designated adult. In order to designate an adult to bring your child into our office for medical care in your absence, you must have the following completed, signed, and on file for each designated adult for each of your children. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form or a signed note from a parent may need to be rescheduled.

Name: HMI Representative **Relationship to Patient**: Loco parentis

Name: _____ **Relationship to Patient**: _____

I attest that the above-named individual(s) are all 18 years of age or older as of this date. I authorize the above-named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures and hospitalizations. This practice may relay any medical information about my child necessary for the above-named individual(s) to provide informed consent to the treatment. I understand that the provider will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary. I agree to hold Rocky Mountain Family Practice and its staff harmless for any disagreement between the above-named individual(s) and myself regarding treatment decisions.

_____ _____

Signature of Parent/Legal Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices. I know that I may request another copy at any time.

AUTHORIZATION AND CONSENT TO TREAT

I give permission to Rocky Mountain Family Practice providers to give me medical treatment. I have the right to discuss all medical treatments with the provider and to refuse any procedure or treatment.

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS & FINANCIAL POLICIES

I have read and understand the **Financial Policy** of Rocky Mountain Family Practice.

I authorize the release of medical information necessary to process all medical claims.

I authorize Rocky Mountain Family Practice to bill my insurance plan for services rendered and hereby assign medical benefits otherwise payable to me to Rocky Mountain Family Practice of Leadville, PC.

I understand and agree that I am financially responsible for all copays, deductibles, coinsurance and services not covered by insurance.

I acknowledge that all information contained on this form is true and accurate. If there are changes to this information, it is my responsibility to provide timely updated information to Rocky Mountain Family Practice to avoid claim denials due to plan timely filing limitations.

This assignment will remain in effect until revoked, by me or my legal representative, in writing. A photocopy of this assignment is to be considered as valid as the original.

ASSIGNMENT OF MEDICAL BENEFITS

I hereby assign benefits to which I am entitled under my health plan, Medicare or CHAMPUS to Rocky Mountain Family Practice of Leadville for services they have rendered to me or my dependents.

NONPAYMENT POLICY

For any account balance over 60 days old, RMFP requires a minimum payment of $40, in addition to any co-pay or high deductible deposit (if applicable), in order to be seen for additional services at Rocky Mountain Family Practice. **Please contact our office if at any time you are having difficulty paying your bill or if you would like to set up a payment plan.** A $25 fee will apply if your account is transferred to an outside agency for formal collections. A $25 fee will apply if a check you have written to us is returned unpaid by your bank.

ACKNOWLEDGMENT AND CONSENT

I have read, understood and agree to the above.

_____ _____

Patient/Legal Representative Signature **Date**

_____ _____

Printed Name of Legal Representative **Patient name if different than Legal Representative**