Rocky Mountain Family Practice, 205 S Main St., Ste B, Longmont, CO 80501

Adult Information Form

Date:_____ Patient:_____

E-Mail Address: _____ Date of Birth:_____

Best Contact Number: _____ SSN#: _____

Address:_____

Gender: _____ Preferred Language: _____

Race: (please circle one)
White Black/African American Asian Native Hawaiian/Other Pac Island

Native American/ Alaskan Declined

Ethnicity: (please circle one) Hispanic Non-Hispanic Declined

Driver's License: _____ Employer: _____

Spouse's Name: _____Phone Number: _____

Whom may we contact in case of an emergency?_____

Phone number: _____

Name of Guarantor or primary insured _____

Insurance Name: _____

Insurance ID Number: _____

Nearest friend not living with you:_____Phone number: _____

How did you learn about us:

Friend__ Family___ Insurance___ Walk-In___ Dr.___ Yellow Pages___ Office website___ Other internet site_____

I will be paying today by Cash_____ Check_____Credit Card_____

Insurance co-payments are due at the time of service. All remaining balances are due at the end of your visit today.

Please show your current insurance card to the receptionist to photocopy your information.
I herby authorize Rocky Mountain Family Practice to furnish information to insurance carriers concerning my diagnosis and treatment as well as billing information.

Signature: _____ Date: _____

Adult – New Patient Medical History

Please fill out a complete medical history for your provider. **(Please Print)**

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Marital Status: Married Single Divorced Widowed

Sex: Male Female (circle one) (circle one)

Please list all medications: Prescriptions and Over the Counter

Medication	Dosage	Instructions

Medication Allergies:

Medication	Reaction

General Allergies:

Pollen, animals, food, environmental:	Reaction:

What is the reason for today's visit?

_____

_____

SYMPTOMS LIST:

Please Write Y (yes) or N (no)

Head and Neck

_____Hearing Loss
_____Ear Pain
_____Sore Throat
_____Pain Swallowing
_____Vocal Hoarseness
_____Nasal Congestion
_____Nose Bleeds
_____Sinus Drainage
_____Lip/Mouth Sores
_____Other_____
_____

Heart

_____Chest Pain
_____Chest Tightness
_____Irregular Heart beat
Or Palpitations
_____Other_____
_____

Lungs

_____Cough
_____Shortness of Breath
_____Wheezing
_____Other_____
_____

Digestive System

_____Heartburn or Excessive
Stomach Acid
_____Nausea
_____Vomiting
_____Abdominal Pain
_____Constipation
_____Diarrhea
_____Other_____
_____

Urinary Tract System

_____Pain or burning with
Urination
_____Blood in Urine
_____Increased Frequency of
Urination
_____Other_____
_____

Nervous System

_____Numbness anywhere
_____Weakness of Limbs
_____Headaches
_____Other_____
_____

Skin and Hair

_____Suspicious Moles
_____Rash
_____Other_____
_____

Female Systems

_____Breast Lumps or
Abnormality
_____Vaginal Discharge
_____Irregular Periods
_____Other_____
_____

Male Systems

_____Testicle Lumps or
_____Swelling
_____Erectile Trouble
_____Other_____
_____

Moods

_____Depression/Sadness
_____Anxiety/Nervous
_____Lack of Motivation
_____Mood Swings
_____Suicidal Thoughts

Please Circle any Symptoms Below

Fever Chills Night Sweats

Weight Loss Weight Gain Fatigue

Smoking, Drinking, Social Drugs

_____Do you smoke?
_____Chew Tobacco
_____Recreational Drugs
_____Drink Alcohol
_____Are you a former smoker?
Please list the amount and how long.

_____
_____
_____

Please list all past medical problems, such as high blood pressure, diabetes, heart disease, asthma, cancer, etc. and when you were diagnosed.

Problem: Time of Diagnosis:

List past Surgeries and Dates

Surgical Procedure: Date:

List past Hospitalizations, Dates and Reasons

Please list Family History of cancer, diabetes, and/or high blood pressure.

Father _____

Mother _____

Siblings_____

_____

Grandparents_____

_____

_____

_____

Revised 8/2014

ROCKY MOUNTAIN FAMILY PRACTICE
James Fretwell M.D.
Brian Hughes D.O.
Paul Cooper M.D.
Ammie Christiansen D.O.

Financial Policy

We are committed to providing you with the best possible care. We are anxious to help you receive your maximum allowable benefits if you have medical insurance. In order to do this, we need your assistance and your understanding of our Financial Policy.

Payment for all services are ***Due at the Time Services are Rendered,*** unless our office manager has approved payment arrangements in advance. We accept ***Cash, Checks, Visa, Discover and Mastercard.*** Returned checks will be subject to a *$35.00 return fee.*

We will be happy to process your insurance claim for your reimbursement. ***A current insurance card must be presented at the time of service*** and ***Copayments are due before your appointment.*** Please be aware that:

1. Your insurance is a contract between You, and/or Your Employer, and the Insurance Company. We are not part of your contract.
2. Not ALL services are a covered benefit for all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
3. If insurance has not paid your claim or responded within 30 days ***the Patient becomes responsible for following up with the insurance company and Payment will be Due.***

MEDICARE clams will be filed and we are very happy to file your secondary insurance; however, at the time secondary insurance is filed it becomes the Patient's responsibility.

We Do Not treat patients for Auto Accidents.

If there is a divorce involved, please remember that our policy requires that regardless of which parent is responsible for bills, **Payment Is Due At The Time Of Service**. As you should be able to understand, we will not get involved with divorce disputes or 3rd party billing. Please feel free to discuss this with our Office Manager if you have any questions. He parent bringing in the child is responsible.

We must emphasize that as provider of medical services, our relationship is with YOU, not your insurance company. While the filing of patient insurance forms is a courtesy that we extend to our patients, all charges are YOUR responsibility from the date the service is rendered. We realize that temporary financial problems may affect timely payment of your account. If problems do arise we encourage you to contact us promptly for assistance in the management of your account.

In the event of default, the outstanding balance shall accrue interest at the rate of 18% per annum from the date of default until paid in full. If the outstanding balance is referred to a collection agency, I/we agree to pay, in addition to interest at the rate of 18% per annum, a reasonable collection fee which shall be 35% of the past due balance and all other costs of collection including but not limited to attorney fees and court costs.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I certify the above information is true and correct to the best of my knowledge. I will notify Rocky Mountain Family Practice of any changes in y status or any information in the New Patient Packet.

I authorize payment of medical benefits to RMFP or supplier for these services an all future claims.

I authorize the release of any medical information necessary to process this claim and all future claims.

_____ _____
Signature Date

_____ _____
Parent (if a Minor) Date

ROCKY MOUNTAIN FAMILY PRACTICE
205 S. Main Street, Suite B
Longmont, CO 80501
Phone: (303) 772-6244

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review this carefully.

Our commitment here at Rocky Mountain Family Practice is to serve our customers with professionalism and caring, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During heath care procedures, we may need a second opinion.

We here at Rocky Mountain Family Practice are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be release with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comment regarding your Protected Health Information, feel free to contact our Compliance Officer: Wanda Jakulewicz at (303) 772-6244.

I have read and understand the above Notice of Privacy Practices.

_____ _____

Signature (Patient or Legal Guardian) Date

_____

Patient Name (Please Print)