ROCKY MOUNTAIN
URGENT CARE & FAMILY MEDICINE

New Patient Registration Form

Please Print Clearly

First Name:_____ Middle Name:_____ Last Name: _____

Street Address:_____ Zip:_____ City:_____

Billing Address:_____ Zip:_____ City: _____

Please check your **primary Phone number and email address*

☐ Cell Phone: _____ ☐ Email Address*:_____

☐ Home Phone: _____ ☐ Email Address*:_____

☐ Work Phone: _____ ☐ Email Address*:_____

Date of Birth: _____ Social Security #:_____

Marital Status: ☐ Divorced ☐ Domestic Partner ☐ Fiancé ☐ Life Partner ☐ Other Sex: ☐ Male
☐ Legally Separated ☐ Married ☐ Single ☐ Widowed ☐ Female

Primary Care Physician:_____ PCP Phone Number: _____

How did you hear About Us?

☐ Existing Patient ☐ Friend/Family ☐ Work ☐ Yellow Pages ☐ Internet: _____

☐ Drive By ☐ Insurance Carrier ☐ School/University ☐ TV/ Radio ☐ Lawyer:_____

Notification Preference: ☐ Phone ☐ Text ☐ Email

Governmental regulations require us to ask the Following questions: ☐ **Patient Refusal**

Race:
☐ American Indian or Alaska Native
☐ Black or African American
☐ Asian ☐ White or Hispanic
☐ Native Hawaiian or other Pacific Islander

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Primary Language: _____

Secondary Language: _____

Insurance Information:_____ ☐ Insurance card provided to front desk

Insurance Company:_____ Policy #: _____

Address:_____ Group #: _____

**On back of card*

Subscriber :_____ Relation to Patient: _____

Street Address:_____ Zip:_____ City:_____

Date of Birth:_____ Social Security #:_____ CoPay: _____

Preferred Pharmacy Name: _____

Pharmacy Cross Streets:_____

Do you have a mail order pharmacy? ☐ No ☐ Yes: _____

If you have both please make which is your preferred pharmacy: ☐ Mail ☐ Retail

Emergency Contact/Relationship:_____ Cell Phone: _____

Patient / Guardian Signature _____ Date _____

With this signature I verify that all information is current and up to date.

By providing my email address and mobile number above I give infinite care holding permission to contact me in the future with educational and patient satisfaction materials. Message and data rates may apply.

Patient Authorizations

Notice of Privacy Practices

I confirm that I have received and reviewed Rocky Mountain Urgent Care & Family Medicine's Notice of Privacy Practices (NPP) on the date indicated. I understand if I have any questions regarding the information contained in this document I can contact Rocky Mountain Urgent Care's Compliance Office at 855.809.7011 or via email at ComplianceOffice@rm-uc.com.

Patient / Guardian Signature Date

Financial Agreement

I confirm that I have received and reviewed Rocky Mountain Urgent Care & Family Medicine's Financial Agreement on the date indicated. I understand if I have any questions regarding the information contained in this document I can contact Rocky Mountain Urgent Care's Billing Office at 877.215.3727 or via email at BillingOffice@rm-uc.com.

I understand I am **NOT** to discuss any financial aspects of my account with the provider or medical staff. If I have questions or comments regarding the financials of my account I am to discuss with a Patient Care Coordinator or a billing specialist.

Patient / Guardian Signature Date

Financial Responsibility, Assignment of Benefits and Release of Medical Records

With the signature below, I authorize Rocky Mountain Urgent Care & Family Medicine to submit claims to insurance carrier(s) along with any medical records required for payment of these claims. If I am seen for a work related injury I understand my employer will receive any medical information required for payment of these claims. I authorized any payment of benefits, payable to me, to be made payable to Rocky Mountain Urgent Care & Family Medicine.

Patient / Guardian Signature Date

Consent for Medical Treatment

With the signature below I authorize Rocky Mountain Urgent Care to perform the medical treatment deemed necessary by the medical provider(s) and their assistants. I also authorize Rocky Mountain Urgent Care & Family Medicine to obtain all medical and prescription history through the electronic medical record system in place.

Patient / Guardian Signature Date

Authorization to Release Protect Health Information

I authorize Rocky Mountain Urgent Care & Family Medicine to release my protected health information via the following methods:

☐ Voicemail: _____ ☐ Email**: _____

I authorize Rocky Mountain Urgent Care & Family Medicine to release specific protected health information in the above method for the following information:

☐ Positive Lab/Path Results ☐ Negative Lab/Path Results ☐ All Lab/Path Results (Positive and Negative) ☐ Radiology Results

Additional Entities to Received my Protected Health Information:

Additional Entities: Please check each entity that is approved to receive information regarding Protected Health Information.	Information to be Released: Select the information that can be released to the entity to the left.
Spouse (List Name and Phone Number)	☐ Financial ☐ Medical
Parent (List Name and Phone Number)	☐ Financial ☐ Medical
Other (List Name, Relationship and Phone Number)	☐ Financial ☐ Medical

Patient / Guardian Signature Date

** By selecting email as a notification above I understand and accept the risk that information could be accessed inappropriately if not sent encrypted.

* Rocky Mountain Family Medicine is a DBA for Potomac Square Family Medicine