Patient Registration Form

Please Print Clearly

*First Name: ______________________________*Last Name: ______________________________

*Date of Birth: ____________ *Sex: ☐ Male ☐ Female Social Security Number: ____________________

*Street Address: ______________________*Apt No: _____*City: ____________*State: ______*Zip: _______

*Home Phone: __________________ *Email Address:______________________________________

Cell Phone: ____________________ Confidential email: ___________________________________

*Primary Care Physician:______________________ *Preferred language: ______________________________

Governmental regulations require us to ask the following question: ☐ **Patient Refusal**

*Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Declined to specify

*Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

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*Preferred Pharmacy Name: ____

Pharmacy Cross Streets: ______________________________________ Zip: ___________________

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

If you have both mark preferred: ☐ Mail ☐ Retail

Emergency Contact Name: _________________________________Relationship: ____________________

Address: ____Phone Number: ____________________

Notification Preference: ☐ Phone ☐ Text ☐ Email: __________________________

Guarantor Name: ________________________________ Relationship: ____________________

Address: ______________________________________ Phone Number: ____________________

*Employer: ____

*How did you hear about us? ____

Insurance Company: ___________________________________Policy #: ___________Group #: __________

Claims Address: ____

Policy Holder Name: ___________________________________Relation to Patient: ____________________

Street Address: ____________________________City: _____________State: ______ Zip: ______________

Date of Birth: _____________Social Security #: ______________________

*Rocky Mountain Family Medicine is billed as Potomac Square Family Medicine

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

Initial ☐

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 877.215.7448

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

Initial ☐

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 clams. I authorized any payment of benefits, payable to me, to be made payable to Rocky Mountain Urgent Care & Family Medicine.

Initial ☐

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 records system in place.

Initial ☐

Authorization to Release Protected 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 Labs/Path Results ☐ Negative Labs/Path Results ☐ All Lab/Path Results (Positive and Negative) ☐ Radiology Results

Additional Entities to Received my Protected Health Information:

Additional Entities: Please complete any other individual who is approved to receive information regarding Protected Health Information.	Information to be Released: Select the information that can be released to the person named
Individual Authorized (List Name and Phone Number)	☐ Financial ☐ Medical

Patient / Guardian Signature: ____

By signing here I verify that all information is accurate and up to date. Date

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