ROCKY MOUNTAIN
URGENT CARE & FAMILY MEDICINE

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: _____

How did you hear about us? ○ Existing Patient ○ Friend/Family ○ Google ○ Insurance Carrier ○ Employer

○ Other: _____

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

*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: _____

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

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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:	Information to be Released:
Please complete any other individual who is approved to receive information regarding Protected Health Information.	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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