Rocky Mountain Family Practice 205 South Main Street, Ste. B, Longmont, Colorado 80501

Child Information Form

Date: _____ Date of Birth: _____

Patient: _____ Best Contact Number: _____

Address: _____

Gender: ____ Preferred Language: _____ SSN #: _____

Race :(circle one) White African-American Nat. American/Alaskan Nat. Hawaiian/Other Pac Island Asian Declined

Ethnicity: (circle one) Hispanic Non-Hispanic Declined

Guarantor or primary insured: _____

Employer: _____ Driver's License: _____

Insurance Name: _____ Insurance ID #: _____

Parent Information

Father's name _____ Date of Birth: _____

Address (if different from above) _____

Phone #: _____ SSN#: _____

E-Mail Address: _____

Mother's name _____ Date of Birth: _____

Address (if different from above) _____

Phone #: _____ SSN #: _____

E-Mail Address: _____

Name of other persons with permission to accompany child to office (grandparents, etc)

_____

_____

Emergency Contact: _____ Phone 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 child's diagnosis and treatment as well as billing information.

Signature: _____ Date: _____

Child – New Patient Medical History

Please fill out a complete medical history for your Provider. (PLEASE PRINT)

Name: _____ Today's Date: _____

Date of Birth: _____ Sex: (circle one) Male Female Age: _____

Parents/Guardians Names and Relationship to Child:

_____

_____

Please list all Medications: Prescriptions and Over the Counter

Medication	Dosage (mg, puffs, etc.)	Instructions

Medication Allergies:

Medication	Reaction

General Allergies:

Pollens, Animals, Food, Environmental	Reaction

List past Hospitalizations, Dates and Reasons

_____

_____

_____

List past Surgeries and Dates

Surgical Procedure	Date

Please list all past medical problems (Asthma, Allergies, Etc.)

Problem	Date of Diagnosis

Were there any problems at birth or in early childhood? Please List.

Are all vaccinations up-to-date? YES NO **Are the Vaccination Records here today?** YES NO

List any vaccines that the child needs. _____

_____

List any Chronic Medical Conditions of Close Family Members (Parents and/or Siblings)

Family Member	Condition

Reason for Todays Office Visit. _____

_____

Symptom List

Please write Y (yes) or N (no) for all of the following

Head and Neck

_____Hearing Loss
_____Pain or plugged ears
_____Sore throat or painful swallowing
_____Nasal Congestion, Sinus Drainage
_____Swollen Glands
_____Nose Bleeds
_____Eye Drainage or Redness
_____Blurred Vision
_____Other _____

Chest

_____Cough
_____Trouble Breathing
_____Sputum Production
_____Wheezing
_____Chest Pain
_____Irregular or Fast Heartbeat
_____Other _____

Stomach

_____Stomach Pain
_____Nausea/Vomiting
_____Constipation
_____Diarrhea
_____Other _____

Urinary

_____Painful Urination
_____Frequent Urination
_____Blood in Urine
_____Incontinence (circle one) Day Night
_____Other _____

Nervous System

_____Headaches
_____Seizures
_____Trouble Sleeping
_____Other _____

Behavioral

_____Trouble with Attention Span
_____Depress Mood
_____Anxiety
_____Hyperactive
_____Other _____

Skin

_____Rash
_____Moles
_____Nail Changes
_____Hair Loss
_____Other _____

Female

_____Vaginal Itching, Burning, or Discharge
_____Vaginal Bleeding
_____Frequent or painful Periods (adolescent)
_____Heavy Periods (adolescent)
_____Other _____

Male

_____Testicle Pain
_____Other _____

General
_____Fever

_____Chills
_____Excessive Weight (circle one) Loss Gain
_____Other _____

ROCKY MOUNTAIN FAMILY PRACTICE
PARENTAL CONSENT FORM

I, _____, being the parent and/or legal guardian of minor child _____ do hereby grant permission for _____ (Caretaker) to consent for medical and/or surgical treatment for said minor child by any licensed medical provider or licensed hospital during the period of time I will be out of town or otherwise unavailable to consent to treatment that may become necessary or desirable to my child.

This consent is expressly designed to release from liability the Medical Provider(s), Hospital(s) and/or Hospital Personnel who may treat said minor child by authority or a consent signed by _____.
Parent and/or Legal Guardian

Authority to consent to treatment should be given to a person over 18 years of age.

Child Information:

Name_____ Date of Birth_____
Date of last tetanus shot_____
Known Drug Allergies_____

Parent/Legal Guardian Information:

_____
Last Name First Name SSN#

_____
Address Phone# Employer

_____Insuranc
e Company Name Address Phone#

_____
Policy/Member ID# Group#

Please attach a copy of Insurance Card

Additional
Information:_____
_____
_____
_____
_____

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)