Patient Information Form 2020

Thank you for choosing Rocky Mountain Family Physicians! RMFP requires all patients to complete a patient information form on a yearly basis to ensure we have up-to-date information. It is important that we have all the below information so please be sure to complete all fields.

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	PCP:

Birth Date:	SSN:	Sex: ◯ M ◯ F	Mailing Address: City: State: Zip Code:

Email Address (This will be used for billing purposes):

Marital Status:	Cell Phone Number:	Alternative Phone Number:
New Patients Only: How did you hear about us?	Ok to leave detailed message: ◯ Yes ◯ No	Ok to leave detailed message: ◯ Yes ◯ No

BILLING INFORMATION

Please fill this section out if the person responsible for out-of-pocket expenses is different than the patient. As a courtesy to our patients, we will bill the health insurance provided. It is your responsibility to provide current insurance at each visit so that we may bill the appropriate insurance in a timely manner and to ensure we are in-network with your specific plan.

Person responsible for bill:	Birth date:	Phone Number:	Relationship to Patient:

Billing Email Address:	Mailing Address *(if different than patient):* City: State: Zip Code:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell Phone:	Alternative Phone:

RMFP 2020 Financial Policy & HIPAA

I consent to Rocky Mountain Family Physicians' use and disclosure of my Protected Health Information to carry out treatment, payment, and healthcare operations.

I acknowledge that the Privacy Practices of Rocky Mountain Family Physicians was made available for my review.

I have reviewed the financial policy and agree to follow the guidelines set forth therein.

I give my permission to release all my medical-related information to the following person(s):

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

Name: ______________________________ Relationship: ________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Rocky Mountain Family Physicians to release any information required to process my claims.

X

Patient (18 years or older) *or* Legal Guardian Signature

Date