Rockpoint
FAMILY MEDICINE

# Patient Registration

## CONFIDENTIALITY & HIPAA COMPLIANCE NOTICE

All information collected on this form is strictly confidential and protected under the Health Insurance Portability and Accountability Act (HIPAA). Your personal and medical information will only be used for treatment, billing, and healthcare operations in accordance with HIPAA regulations. We take every precaution to safeguard your privacy and ensure your data remains secure. If you have any questions regarding your privacy rights, please ask our staff.

## PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Preferred First Name _____ Date of Birth _____ Social Security Number _____

Address _____ Apartment Number _____

City _____ State _____ Zip Code _____

Preferred Phone Number _____ ☐ Cell ☐ Home ☐ Work Email Address _____

Is it ok to leave a message with detailed medical or billing information on your preferred phone? ☐ Yes ☐ No

For appointments or medical information, I consent to (select all that apply): ☐ Phone ☐ Text ☐ Email

### Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Decline to answer

### Employment Status

☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Active Military

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____

### Race / Ethnicity

☐ American Indian / Alaska Native ☐ African American / Black ☐ Asian ☐ Caucasian / White ☐ Hispanic / Latino

☐ Middle Eastern / North African ☐ Native Hawaiian / Pacific Islander ☐ More than one race ☐ Unknown / Other Race

### Gender at Birth

☐ Male ☐ Female

### Gender Identity

☐ Identifies as Male ☐ Identifies as Female ☐ Non-binary ☐ Decline to answer

### Sexual Orientation

☐ Heterosexual / Straight ☐ Homosexual / Gay / Lesbian ☐ Bisexual ☐ Decline to answer

### Pronouns

☐ He / Him ☐ She / Her ☐ They / Them ☐ Other: _____

### How did you hear about Rockpoint Family Medicine?

☐ Insurance ☐ Family / Friend ☐ Online Search ☐ Social Media ☐ Other



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Last Name _____ First Name _____ Social Security Number _____

## EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone Number _____

Name _____ Relationship _____ Phone Number _____

## PHARMACY INFORMATION

Pharmacy Name _____ Cross Streets _____ Phone Number _____

## INSURANCE INFORMATION

### PRIMARY Insurance Carrier

Name _____ Phone Number _____

ID / Policy Number _____ Group Number _____

### PRIMARY Insurance Policyholder

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Social Security Number _____ Phone Number _____

Employer _____ Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse

### SECONDARY Insurance Carrier

Name _____ Phone Number _____

ID / Policy Number _____ Group Number _____

### SECONDARY Insurance Policyholder

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Social Security Number _____ Phone Number _____

Employer _____ Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse

## RELEASE OF BENEFITS AND ACKNOWLEDGMENT

I attest that the information is correct to the best of my knowledge. I authorize the release of any medical information that may be requested by the above-named insurance carrier(s) in order to process a claim for benefits.

Patient Name _____ Signature _____ Date _____

Legal Guardian Name (if Minor) _____ Signature _____ Date _____



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# Patient Health History

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## PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Gender: ☐ Male ☐ Female ☐ Other

## MEDICATIONS + SUPPLEMENTS

**Please list any medication(s) you are currently taking, including prescribed medications, vitamins, supplements, and over-the-counter medications.**

| MEDICATION | DOSAGE / DIRECTIONS | PROBLEM BEING TREATED | PRESCRIBING DOCTOR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## ALLERGIES

**Please indicate your known allergies using the checklist below.** ☐ **I have no known allergies**

☐ Anesthesia
☐ Antibiotics
☐ Aspirin / Ibuprofen / NSAIDS
☐ Bentadine
☐ Chemotherapy Drugs
☐ Codene
☐ Contact Dermatitis
☐ Iodine
☐ Insulin
☐ IVP Dye
☐ Latex
☐ Penicillin
☐ Sulfa
☐ Tape
☐ Other: _____

Please describe your reaction(s) to allergens _____

## CURRENT TREATING PROVIDERS / SPECIALISTS

Cardiologist _____ Gynecologist _____ Pulmonologist _____

Endocrinologist _____ Neurologist _____ Other: _____



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Last Name _____ First Name _____ Social Security Number _____

## PAST MEDICAL HISTORY

**Check all conditions you have now or have had in the past.**

### AUTOIMMUNE DISEASE

- ☐ Celiac
- ☐ Lupus
- ☐ Rheumatiod Arthritis
- ☐ Other: _____

### BLOOD + LYMPH NODE

- ☐ Anemia
  - ☐ Aplastic ☐ Chronic Disease ☐ Hemolytic
  - ☐ Iron Deficiency ☐ Sickle Cell
  - ☐ Thalassemia ☐ Vitamin B Deficiency
  - ☐ Other: _____
- ☐ Blood Clotting Disorder
- ☐ Hemophilia
- ☐ Lupus
- ☐ Lyme's Disease
- ☐ MRSA

### BONES, JOINTS + MUSCLES

- ☐ Arthritis
- ☐ Fybromyalgia
- ☐ Gout
- ☐ Osteoporosis

### BRAIN + NERVOUS SYSTEM

- ☐ Alzheimer's Disease
- ☐ Concussion
- ☐ Dementia
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Stroke / CVA / TIA

### CANCER

- ☐ Type _____ Year _____
- ☐ Type _____ Year _____
- ☐ Type _____ Year _____
- ☐ Type _____ Year _____

### CARDIOVASCULAR

- ☐ Angina
- ☐ Arrhythmia / Irregular Heartbeat
- ☐ Atrial Fibrillation
- ☐ Implantable Cardioverter Defribrillator
- ☐ Blood Clots
- ☐ Heart Attack / MI
- ☐ Heart Disease / CAD
- ☐ High Cholesterol / Hyperlipidemia
- ☐ Hypertension / High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Stent
- ☐ Varicose Veins / PVD

### HEAD, EYES, EARS, NOSE + THROAT

- ☐ Blindness
- ☐ Deafness
- ☐ Glaucoma
- ☐ Hearing Loss

### HORMONES + METABOLIC

- ☐ Diabetes ☐ Type 1 ☐ Type 2 ☐ Unknown
- ☐ Hemoglobin A1C
- ☐ Blood Pressure ☐ High ☐ Low
- ☐ Thyroid Cancer

### IMMUNE DISEASE

- ☐ AIDS Date: _____
- ☐ HIV Date: _____

### KIDNEYS + URINARY TRACT

- ☐ Renal Failure
- ☐ Renal Insufficiency
- ☐ UTI

### MENTAL HEALTH

- ☐ ADD / ADHD
- ☐ Anxiety / Depression
- ☐ Bipolar Disorder
- ☐ Drug / Alcohol Abuse
- ☐ Other: _____

### PULMONARY / RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Currently Uses a CPAP Machine
- ☐ Emphysema
- ☐ Pulmonary Embolism
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ Valley Fever

### STOMACH + DIGESTIVE

- ☐ Acid Reflux / GERD
- ☐ Appendectomy
- ☐ Cirrhosis of the Liver / Liver Disease
- ☐ Colon Polyps
- ☐ Crohn's Disease
- ☐ Hepatitis ☐ A ☐ B ☐ C ☐ Unknown
- ☐ Hernia
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Stomach Ulcer
- ☐ Ulcerative Colitis



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## PAST SURGICAL HISTORY

- ☐ Aneurysm
- ☐ Angioplasty
- ☐ Angioplasty with Stent
- ☐ Appendectomy
- ☐ Arthroscopy ☐ Right ☐ Left
  Location: _____
- ☐ Back Surgery
  Location: _____
- ☐ Breast Surgery
  - ☐ Full Mastectomy
  - ☐ Partial Mastectomy ☐ Right ☐ Left
  - ☐ Lumpectomy ☐ Right ☐ Left
  - ☐ Augmentation ☐ Right ☐ Left
  - ☐ Reduction ☐ Right ☐ Left
- ☐ Cardiac / Heart Surgery
- ☐ Cataract Extraction ☐ Right ☐ Left
- ☐ Colectomy
- ☐ Colonoscopy
- ☐ C-Section
- ☐ D&C
- ☐ Ear Tubes
- ☐ Gallbladder
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement ☐ Right ☐ Left
- ☐ Hysterectomy ☐ Partial ☐ Complete
- ☐ Knee Replacement ☐ Right ☐ Left
- ☐ Prostate
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy

### OTHER SURGERIES NOT LISTED

- ☐ _____
- ☐ _____
- ☐ _____

### CURRENTLY BEING TREATED WITH:

- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Oxygen ☐ Day ☐ Night
  Liters: _____

### ANESTHESIA

- ☐ Issues with Past Anesthesia (List Below)

_____

_____

## FAMILY HEALTH HISTORY

- ☐ **No Significant Family History Known**
- ☐ Alcohol / Drug Abuse ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Asthma
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Bipolar
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Bleeding Disorder
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Cancer
  Type _____ ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
  Type _____ ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
  Type _____ ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Dementia ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Depression / Anxiety
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Diabetes ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Epilepsy
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Emphysema (COPD) ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Glaucoma
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Gout
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Heart Disease ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ High Blood Pressure
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ High Cholesterol ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Kidney Disease ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Migraines
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Osteoarthritis
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Schizophrenia
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Stroke ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Sickle Cell Anemia ☐ Cause of Death
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Thyroid Disease
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Tuberculosis
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Other _____
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Other _____
  ☐ Mother ☐ Father ☐ Sister ☐ Brother
- ☐ Other _____
  ☐ Mother ☐ Father ☐ Sister ☐ Brother



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## SOCIAL HISTORY

### TOBACCO USE

☐ Never

☐ Second-hand Exposure

☐ Former User Number of Years: _____

- ☐ Cigarettes / Cigar / Pipe
  - ☐ Occasional
  - ☐ Daily Amount: _____
- ☐ e-Cigarettes
  - ☐ Occasional
  - ☐ Daily Amount: _____
- ☐ Smokeless / Snuff / Chew
  - ☐ Occasional
  - ☐ Daily Amount: _____

☐ Current User Number of Years: _____

- ☐ Cigarettes / Cigar / Pipe
  - ☐ Occasional
  - ☐ Daily Amount: _____
- ☐ e-Cigarettes
  - ☐ Occasional
  - ☐ Daily Amount: _____
- ☐ Smokeless / Snuff / Chew
  - ☐ Occasional
  - ☐ Daily Amount: _____

### ALCOHOL USE

Have you had a drink containing alcohol in the past year?

☐ No ☐ Yes

If yes, how often did you have a drink containing alcohol in the past year?

☐ Monthly or less
☐ 2-4 times a month
☐ 2-3 times a week
☐ 4+ times a week

If yes, how many drinks did you have on a typical day?

☐ 1-2 ☐ 3-4 ☐ 5-6
☐ 7-9 ☐ 10+

What type of alcohol do you drink?

☐ Beer
☐ Wine
☐ Hard Liquor

### RECREATIONAL DRUG USE

☐ Never

☐ Former User Number of Years: _____

☐ Current User Number of Years: _____

If current or former, what type(s)? _____

_____

### VAPE USE

☐ Never

☐ Former User Number of Years: _____

☐ Current User Number of Years: _____

- ☐ Cigalikes
  - ☐ Occasional
  - ☐ Daily Strength: _____
- ☐ Podkits
  - ☐ Occasional
  - ☐ Daily Strength: _____
- ☐ Pen
  - ☐ Occasional
  - ☐ Daily Strength: _____
- ☐ Box Mods
  - ☐ Occasional
  - ☐ Daily Strength: _____

### CAFFEINE USE

☐ Never

☐ Occasional

Type: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink

Amount: _____

☐ Daily

Type: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink

Amount: _____



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# Financial/Privacy

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## CONSENT FOR CARE AND TREATMENT

I understand and agree to give my consent to Rockpoint Family Medicine (RFM) to provide medical care, recommendations, and treatment considered necessary and proper in diagnosing or treating the undersigned patient.

Patient's Last Name _____ Patient's First Name _____ Patient's Date of Birth _____

Patient / Responsible Party's Signature _____ Date _____

## FINANCIAL POLICY / NOTIFICATION OF PATIENT RESPONSIBILITY

RFM will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. It is the responsibility of the patient to make sure we are assigned as your PCP, and in your network. It is the responsibility of the patient to be sure they acquire the appropriate referrals and / or prior authorizations as needed by the insurance company. In the event your insurance copay establishes a usually and customary fee schedule, you will be responsible for the remaining balance.

Patient's Last Name _____ Patient's First Name _____ Patient's Date of Birth _____

Patient / Responsible Party's Signature _____ Date _____



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# Patient Policies & Guidelines

## Welcome

Our goal is to provide high quality, compassionate care. In order to achieve this goal, we have established the following set of policies.

## Clinical Policies

1. Please bring all medications, or a current list of your medications, and a copy of your insurance card to your appointments so that we can prescribe effective, safe, and affordable medications for you.
2. Please arrive 10 minutes prior to your appointment if you are an established patient and 30 minutes prior if you are a new patient. This allows your provider to see you at your scheduled appointment time. You may be required to reschedule if late for an appointment.
3. Please call the office to schedule an appointment if you have an acute problem. We will do our best to see you on the day of your call and help you avoid an urgent care visit.
4. Appointments may be scheduled, rescheduled, or canceled by calling our office or via our online patient portal.
5. Multiple no-shows or late cancellations / reschedules for appointment may result in termination as our patient.
6. Medications will be refilled during office hours only. Please let us know if refills are needed at your appointments. Refills requested outside of an office visit may incur a $25 fee. If your chronic medications are out of refills, you will be required to schedule an appointment with your provider.
7. Please allow 24 hours for responses to questions you may have outside of office visits. We are usually not able to address questions / requests until lunch or after all patients for the day are seen. Please avoid leaving multiple messages for the same request or question.
8. Acute and chronic health problems may not be able to be addressed at a single office visit. If you have multiple issues, several visits may be required to meet your health needs. This helps us provide quality patient care and allows us to stay on time for all scheduled appointments.
9. A complete physical is considered a preventative visit during which we will update your medical history, perform a thorough physical exam, and recommend appropriate labs and screening tests based on your age and medical history. Acute problems / chronic medical issues are typically not addressed during this visit. We recommend scheduling a separate appointment to allow time to adequately address chronic or acute medical issues. If both a preventative and chronic / acute medical issue visit are performed at the same visit, the patient will be responsible for the balance not paid by their insurer.
10. Sports, camp, and college physicals are often not covered by insurers. Most, however, will cover preventative visits and well checks. Please bring required forms and immunization records to the visit and we will be happy to complete them for you.
11. Letters and form completion (FMLA, Disability, etc.) outside of an office visit will incur a $25 fee and is not billable to insurance.



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## Financial Policies

1. It is the responsibility of the patient to make sure we are assigned as your PCP, and in your network. It is the responsibility of the patient to be sure they acquire the appropriate referrals and / or prior authorizations as needed by the insurance company. In the event your insurance copay establishes a usually and customary fee schedule, you will be responsible for the remaining balance.
2. Patients are expected to pay for co-pays, deductibles, and co-insurances and past balances at the time of service. Any overdue accounts that go beyond 60 days will be turned over to an outside collections agency. All collection agency fees, including but not limited to, submission fees and percent of debt fees (up to 50%) will become patient responsibility.
3. Please notify the office at least 24 hours prior to your appointment if you need to cancel or reschedule. Failure to cancel or reschedule appointments with at least 24 hours' notice will incur a fee of $40 for regular appointments or $60 for procedures, ultrasounds, ECHOS, physicals, or new patient visits.
4. We accept credit cards (Visa, MasterCard, American Express, and Discover), cash, and personal checks for account balances. A $35 fee will be charged for any checks returned for insufficient funds.

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**By signing this document, I acknowledge that I have read, understand, and agree to Rockpoint Family Medicine's Clinical and Financial Policies, and authorize Rockpoint Family Medicine to:**

- File insurance claims on my behalf for services rendered and I assign my insurance benefits to be paid directly to Rockpoint Family Medicine
- Release medical information to process my claim(s)
- Obtain / have access to my medication history
- Obtain / have access to health information exchange

Patient Name _____ Date _____

Patient Signature (or Legal Representative) _____ Date _____

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# Thank you for choosing us.

We're committed to delivering a welcoming, professional, and patient-centered experience at Rockpoint Family Medicine. Your health, comfort, and satisfaction are our top priorities, and we strive to provide exceptional care with every visit.



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# HIPAA Notification of Privacy Practices

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## Uses & Disclosures of Protected Health Information

Our protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

### Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

### Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

### Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health in related benefits and services that may be of interest to you.

We may use or disclose your protected health information the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

## Uses and Disclosures That Require Your Authorization

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.



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## Your Rights

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply).**
Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records:

- Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law,
- Information that is related to medical research in which you have agreed to participate,
- Information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information.**
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any or part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications**
You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to request an amendment to your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures; pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached. You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## Complaints

You may file a complaint with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the following "Acknowledgment" form. Please note that by signing the "Acknowledgment" form you are only acknowledgment that you have received or been given the opportunity to receive a copy of our Notice of privacy practices.

Patient Name _____ Date _____

Patient Signature (or Legal Representative) _____ Date _____



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# Authorization for Use and Disclosure of Protected Health Information

## CONFIDENTIALITY & HIPAA COMPLIANCE NOTICE

All information collected on this form is strictly confidential and protected under the Health Insurance Portability and Accountability Act (HIPAA). Your personal and medical information will only be used for treatment, billing, and healthcare operations in accordance with HIPAA regulations. We take every precaution to safeguard your privacy and ensure your data remains secure. If you have any questions regarding your privacy rights, please ask our staff.

**Completion of this document authorizes the disclosure and use health information about you. Failure to provide all information requested may invalidate this authorization**

## PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Preferred First Name _____ Date of Birth _____ Social Security Number _____

Address _____ Apartment Number _____

City _____ State _____ Zip Code _____

Preferred Phone Number _____ ☐ Cell ☐ Home ☐ Work Email Address _____

## DESIGNATED PERSON(S)

Last Name _____ First Name _____ Phone Number _____

Last Name _____ First Name _____ Phone Number _____

Last Name _____ First Name _____ Phone Number _____

Last Name _____ First Name _____ Phone Number _____

1. I authorize Rockpoint Family Medicine (RFM) to obtain/release/exchange my health information specific to the following date or time period: _____ or ☐ All episodes of care

2. ☐ **OBTAIN FROM:**

   **Provider:** _____

   **Address:** _____

   **Phone:** _____

   **Fax:** _____

   ☐ **RELEASE TO:**

   **Provider / Medical Facility:** Rockpoint Family Medicine

   **Address:** 3875 E Williams Field Rd., Suite 101, Gilbert, AZ 85295

   **Phone:** 480-568-7180

   **Fax:** 480-568-7185

3. Patients may elect to have copies of their medical records provided electronically.
   Please check to indicate your wish to have your medical records provided in an electronic format to the email provided below:
   ☐ Email address: _____



ROCKPOINT FAMILY MEDICINE
3875 E. Williams Field Rd. Ste. 101, Gilbert, AZ 85295 480.568.7180 480.568.7185 rockpointfm.com

Last Name _____ First Name _____ Social Security Number _____

4. Purpose for which disclosure is to be made: _____
5. Information to be disclosed / exchanged:
   ☐ Consultations ☐ Discharge Summary ☐ Emergency Dept. Reports ☐ History + Physical Exam
   ☐ Laboratory Report ☐ Medications ☐ Office Notes ☐ Operative Report ☐ Pathology ☐ Progress Notes
   ☐ Radiology Report ☐ Print ☐ Electronic ☐ Both ☐ Other: _____
   EXAM: _____
6. I understand that if the person(s) or entity(s) that receives the information is not a healthcare provider or health plan covered by federal privacy regulation, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release RFM, its employees and contractors from all liability arising from this disclosure of my health information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
7. I understand that RFM may receive compensation for the authorized use/disclosure of this information.
8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the department that provided the information, knowing that previously-disclosed information would not be subject to my revoke request.
9. I understand that I may refuse to sign this authorization and that my refusal to sign will not reflect my ability to obtain treatment, payment or eligibility for benefits.
10. I understand that this authorization shall be retained as a part of my protected health information in accordance with applicable RFM policy. I have received a copy of this authorization.
11. This authorization expires on _____ or ninety days from the date this authorization was signed. I further understand that I may revoke this authorization in writing at anytime except to the extent that action has been taken on it.

Patient Signature (or Legal Representative) _____ Date _____

Relationship to Patient if Signature is other than Patient _____

## Office Use Only

☐ Photo ID verified

By _____ Receipt Date/Time _____ / _____



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FAMILY MEDICINE

# Credit Card Authorization

Please complete all fields. You may cancel this authorization at any time by contacting us.
This authorization will remain in effect until canceled.

**Credit Card Information Card Type:** ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other_____

**Cardholder Name (as shown on card):** _____

**Card Number:** _____

**Expiration Date (mm/yy):** _____

**Cardholder ZIP Code (from credit card billing address):** _____

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I, _____, authorize Rockpoint Family Medicine to charge my credit card above for medical treatment. I understand that my information will be saved to file for future transactions on my account.

Patient Signature _____ Date _____



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