Rocky Mountain Internal Medicine, PC

Aurora	Denver	Montbello	Strasburg
1360 S. Potomac St.	4100 W. 38th Ave.	4896 Chambers Rd.	56441 E. Colfax Ave.
Aurora, CO 80012	Denver, CO 80212	Denver, CO 80239	Strasburg, CO 80136
(P) 303-337-5575	(P) 303-433-2565	(P) 303-371-7263	(P) 303-622-9241
(F) 303-745-6264	(F) 303-433-2567	(F) 303-371-3562	(F) 303-622-6880

TODAY'S DATE _____

Is your condition a result of an injury? Yes ☐ No ☐ If yes, complete ACCIDENT section.

PATIENT'S NAME: _____Age: _____Male ☐ Female ☐

Marital Status: _____ Date of Birth:_____ Soc. Sec. # _____

Mailing Address: _____ Apt # _____

City: _____ County: _____ State: _____Zip Code: _____

E-mail : _____ *by proving your email you are approving to receive emails from RMIM.

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Employer:_____ Occupation: _____

Spouse or Parent's Name: _____ Date of Birth: _____

Employer: _____Work Phone # _____

PRIMARY INSURANCE: _____ Copay $ _____

Address: _____ Phone # _____

Insured/Employee Name: _____ Date of Birth : _____

ID # _____ Group # _____

SECONDARY INSURANCE: _____ Copay $ _____

Address: _____ Phone # _____

Insured/Employee Name: _____ Date of Birth: _____

ID # _____ Group # _____

Accident Information: Date of Accident/Injury: _____Auto ☐ Work ☐ Other☐

Brief Description: _____

Name of Nearest Relative not living with patient: _____

Relationship & Phone # _____

ASSIGNMENT

I hereby assign benefits for all medical/surgical expenses to RMIM. I Understand that I am financially responsible for all charges not covered by this assignment of benefits, and for all co-payments and deductibles. I also authorize release of any medical records or medical information to any insurance company, medical facility, or physician. I also hereby authorize the release of my medical records by a medical facility, or physician upon request of RMIM. I understand that if I allow my account to become past due to the point it will sent to a collection agency, and I will also be responsible for other legal fees. E-mail is also provided so we can provide you securely with reports, results, etc.

PATIENT'S SIGNATURE/GUARDIAN _____Date: _____

Rocky Mountain
RMIM Internal Medicine, PC.

Statement of Patient Financial Responsibility
Responsabilidad Financiera del Paciente

I understand that my insurance may not cover my visits.
If my insurance denies payment, I agree to be personally and fully responsible for payment.

Entiendo que mi seguro tal vez no cubra alguna o todas de mis visitas.
Si mi seguro niega el pago, acepto asumir la responsabilidad total del pago.

Name: _____
(Nombre)

Signature: _____
(Firma)

Date: _____/_____/_____
(Fecha)

Rocky Mountain Internal Medicine, PC.

HIPAA ACKNOWLEDGEMENT OF RECEIPT
(HIPAA ACUSE DE RECIBO)

We at Rocky Mountain Internal Medicine and its subsidiaries are required by law to maintain the privacy of and provide individuals with our Notice of Legal Duties and Privacy Practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer by calling our main phone number at (303) 337-5575.

If you would like a copy of the Notice, please ask and one will be provided.

Nosotros en el Rocky Mountain Medicina Interna y sus filiales están obligados por ley a mantener la privacidad de los individuos y proporcionar con nuestra Aviso Sobre Practicas de con respecto a la información de salud protegida. Si usted tiene alguna objeción a la notificación, por favor pida hablar con nuestro Oficial de Cumplimiento HIPAA llamando a nuestro número de teléfono principal en el (303) 337-5575.

Si desea una copia de la Notificación, por favor pregunte y uno será proporcionado.

Patient Name _____ Date of Birth _____
(Nombre) (Fecha de Nacimiento)

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document, that I have had the opportunity to ask and have any questions answered, and that I have been provided a copy of the Notice if I requested one.

Por la presente declaro que he revisado el Aviso de Privacidad HIPAA del documento práctica, que he tenido la oportunidad de hacer y tener cualquier pregunta contestada, y que se me ha facilitado una copia de la notificación si me pide una.

_____ _____
Signature of patient or patient's representative/parent Date
(Firma del paciente o representante del paciente/padre) (Fecha)

_____
Printed name of patient or patient's representative/parent
(Nombre complete del paciente o el representante del paciente/padre)

_____
Relationship to patient
(Relación con el paciente)

We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facilities, and it will also be posted on our web site at http://www.rmimpc.com.

Revision: March 2015

Rocky Mountain Internal Medicine, PC.

HIPAA 3rd PARTY AUTHORIZATION FORM

In compliance with RMIM Privacy Practices this form will allow you to designate an individual(s) to whom RMIM and its subsidiaries may disclose your protected health information. This may include individually identifiable information related to past, present or future appointment, medical or financial information. This does not include information relating to mental health treatment or HIV test results as releasing that information requires your separate written consent.

Patient Name _____Date of Birth _____

Address _____City_____State:_____Zip_____

Telephone Number: (_____)_____

I do hereby authorize RMIM to disclose protected health information to the following:

1. _____ _____ **(____)**_____
Name Relationship to patient Telephone number

2. _____ _____ **(_____)**_____
Name Relationship to patient Telephone number

3. _____ _____ **(_____)**_____
Name Relationship to patient Telephone number

By signing below I acknowledge that I have had full opportunity to read and consider the content of this authorization and understand that my protected health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude RMIM from disclosing my protected health information as outlined by RMIM Health Privacy Practices.

I understand that I have the option to revoke this authorization at anytime except to the extent that action has already been taken in reliance upon it. I also understand that unless revoked in writing by completing a new authorization form, this authorization will remain in effect until I choose to revoke it.

_____ _____
Patient Signature Date

_____ _____
Personal Representative (Relationship to Patient) Date

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HISTORY AND PHYSICAL FORM

Patient Name: _____ Date of Birth: _____

Date: _____ Age: _____

Chief Complaint: _____
_____
_____

History:_____
_____
_____
_____
_____
_____
_____

Past Medical History: (List all medical problems you have had)
_____
_____
_____
_____
_____

Past Surgical and Obstetric History: (List all surgical operations/pregnancies you have had)
_____
_____
_____
_____

Allergies: Are you allergic to any medicines? (including iodine, latex, tape.) Indicate type of reaction.
_____
_____
_____
_____

Medications: (List any medicines, steroids, or drugs, vitamins, herbs, diet, etc, taking now)

Medication	Dose	Frequency

Medication	Dose	Frequency

Are you using Oxygen at home? (name company and phone # if possible): _____

Do you receive home health care? (name and phone #): _____

SOCIAL HISTORY:

Do you exercise?	No	Yes	How many days a week? _____	
Do you smoke?	No	Yes	How much _____ per day?	Quit? When _____
Do you chew tobacco?	No	Yes	How much _____ per day?	Quit? When _____
Do you drink alcohol?	No	Yes	If yes, how often? _____	
Do you use any street drug?	No	Yes	If yes, what kind? _____	
Are you on a special diet?	No	Yes	If yes, describe: _____	

What kind of work do you do? _____

FAMILY MEDICAL HISTORY - Please indicate is any family member has had the following:

			Relationship				Relationship
Cancer (what kind)	No	Yes	_____	Bleeding problems	No	Yes	_____
Blood pressure problems	No	Yes	_____	Diabetes	No	Yes	_____
Heart problems/heart attack	No	Yes	_____	Epilepsy/seizures	No	Yes	_____
High cholesterol	No	Yes	_____	Asthma/breathing problems	No	Yes	_____
Depression	No	Yes	_____	Reaction to anesthesia	No	Yes	_____
				Osteoporosis	No	Yes	_____

MEDICAL HISTORY - Have you been diagnosed with and/or are you currently having any of the following symptoms:

Neurologic IHEENT:

Have you had any neurological problems?	No	Yes
Numbness/ tingling	No	Yes
Loss of strength	No	Yes
Stroke (CVA/TIA)	No	Yes
Headaches-type	No	Yes
Seizures/ epilepsy	No	Yes
MS (multiple sclerosis)	No	Yes
Ear problems	No	Yes
Eye problems	No	Yes
Nose/sinus problems	No	Yes
Throat problems	No	Yes

Do you have any muscle/bone problems?	No	Yes
Back or neck problems/joint pain	No	Yes
Loss of sensation	No	Yes
Rash/skin breakdown	No	Yes
Arthritis (type)	No	Yes
Fractures	No	Yes
Osteoporosis	No	Yes

Cancer:

Have you ever been diagnosed with cancer?	No	Yes

Type: _____

Treatment: _____

Endocrine:

Have you had problems?	No	Yes
Tired/ sluggish	No	Yes
Excessive thirst	No	Yes
Diabetes	No	Yes
Thyroid	No	Yes

Respiratory:

Have you had any breathing problems?	No	Yes
Wheezing	No	Yes
Shortness of breath	No	Yes
Productive or bloody cough	No	Yes
Asthma	No	Yes
Emphysema.COPD	No	Yes
Bronchitis	No	Yes
Pneumonia	No	Yes
Pulmonary embolism	No	Yes
TB test or PPD	No	Yes

Cardiac: **Musculoskeletal skin:**

Have you had any heart problems?	No	Yes
Chest pain (angina)	No	Yes
Palpitations/ heart racing	No	Yes
Congestive heart failure	No	Yes
Heart Attack	No	Yes
High blood pressure	No	Yes
High Cholesterol	No	Yes
Pacemaker	No	Yes
Heart valve	No	Yes
Rheumatic fever	No	Yes

Sleep Problems:

Do you have sleeping problems?	No	Yes
Do you snore?	No	Yes
Do you have leg cramping at night?	No	Yes
Do you have insomnia?	No	Yes
Do you get sleepy during the day?	No	Yes
Do you get sleepy while driving?	No	Yes
Do you get sleepy at work?	No	Yes

Name: _____

DIGESTIVE (stomach bowel)

Have you had any digestive problems?	No	Yes
Abdominal Pain	No	Yes
Nausea/vomiting	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Colitis	No	Yes
Diverticulitis	No	Yes
Hiatal hernia/reflux	No	Yes
Irritable bowel syndrome	No	Yes
Ulcers	No	Yes
Pancreatitis	No	Yes
Rectal bleeding/rectal pain	No	Yes
Change in bowel habits	No	Yes
Hemorrhoids	No	Yes

WOMEN/GYN:

Last menstrual period(1st day of menses)	Date _____	
Last mammogram (date and findings)	No	Yes
Last pap smear (date and findings)	No	Yes
Kidney problems/stones	No	Yes
Kidney failure	No	Yes
# of pregnancies/ # of kids	_____/_____	
Uterine problems	No	Yes
Ovarian problems	No	Yes
Urinary urgency (rush to bathroom)	No	Yes
Unable to hold urine (having accidents)	No	Yes
Sexual dysfunction	No	Yes

IMMUNIZATIONS (Date)

Tetanus _____ Flu shot _____
Hepatitis A/B _____ MMR _____
Pneumonia _____ Varicella/Zostavax _____

STOP!!!!!!!

Male Genital:

Enlarged prostate?		
Urinary frequency	No	Yes
Urinary urgency?	No	Yes
Waking up multiple times at night to pass urine	No	Yes
Erectable dysfunction?	No	Yes

BLOOD IMMUNE SYSTEM

Any problems?	No	Yes
Swollen glands	No	Yes
Anemia	No	Yes
Cirrhosis	No	Yes
Blood clots in veins	No	Yes
Jaundice	No	Yes
Lupus	No	Yes

PHYCHOLOGIC (EMOTIONAL)

Any problems?	No	Yes
Nervousness	No	Yes
Anxiety	No	Yes
Depression	No	Yes
Other	No	Yes

CONSTITUTIONAL

Any problems?	No	Yes
Fever	No	Yes
Chills	No	Yes
Weight Loss or gain	No	Yes
Night sweats	No	Yes

COMMINICABLE DISEASES

Any problems?	No	Yes
AIDS/HIV	No	Yes
Hepatitis	No	Yes
Sexually transmitted disease	No	Yes
Tuberculosis	No	Yes

PHYSICAL EXAMINATION

General: Weight: _____ Height: _____
Ectophorm: _____ Mesophorm: _____ Endomorph: _____

Vital Signs: BP_____ mmHg, Pulse _____rpm, RR _____rpm, Temp. _____ F

Heent: Ears
Eyes_____ Vision_____ Conjunctives _____
Nose_____
Mouth_____
Pharynx_____ Tongue_____ Teeth/Gums _____
Fundi

Neck:
Trachea _____
Carotid Bruits_____
Juglars _____
Thyroid _____
Lymph nodes _____

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ePrescribing Medication History Consent Form

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Rocky Mountain Internal Medicine can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Rocky Mountain Internal Medicine to enroll me in the ePrescribe Program. I also understand I can revoke my authorization at any time by providing a written statement. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Consentimiento de ePrescribing

ePrecribing se define como la capacidad de los médicos para enviar electrónicamente la prescripción precisa, comprensible y sin errores a las farmacias desde su centro de cuidado. El congreso ha determinado que la habilidad de enviar electrónicamente las prescripciones, es un elemento importante para mejorar la calidad del cuidado de los pacientes. Eprescribing reduce enormemente los errores en las medicinas dando mayor seguridad al paciente. La ley Moderna del Medicare (MMA) del 2003 tiene normas que deben ser agregadas en un programa de ePrescribing. Estas incluyen:

- **Formulario y el beneficio de una transacción**— Da al médico la información acerca de que medicinas cubre el plan de beneficios.
- **Historia de las transacciones en las medicinas**- Provee al médico con información acerca de las medicinas que el paciente está tomando para minimizar la cantidad de efectos adversos.
- **Completa el estado de notificación**- Permite al médico recibir electrónicamente el aviso, desde la farmacia, que le dice si el paciente recibió o no la prescripción o solo fue dada parcialmente.

Al firmar este consentimiento usted está de acuerdo en que Rocky Mountain Internal Medicine pueda solicitar y hacer uso del historial de sus medicamentos recetados por otros médicos y/o de sus beneficios de farmacia para propósitos de tratamiento.

Entendiendo todo lo anterior, Yo doy el consentimiento a Rocky Mountain Internal Medicine para inscribirme en el programa ePrescribing. Comprendo también que puedo revocar mi autorización en cualquier momento mediante una declaración escrita. He tenido la oportunidad de hacer preguntas y todas ellas han sido contestadas a mi satisfacción.

Printed Name of Patient Nombre del Paciente en Imprenta	Date of Birth Fecha de Nacimiento	Today's Date Fecha
Signature of Patient or Guardian	Printed Name of Guardian (if applicable) Nombre del Paciente en Imprenta	Relationship to Guardian Relación con el Guardián