PATIENT REGISTRATION

Please note (*) is optional information

Patient name: Last _____First _____ MI_____ DOB: _____

Social Security Number: _____-_____-_____Sex: M / F Circle one: Married / Single / Divorced / Widow(er)

Address_____
(Street) (City/State/Zip)

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

*Email Address: _____

***Email Opt Out:** Please do NOT use my email address for communications involving:
☐Appointment Reminders ☐Medical Test Results ☐Clinic Tips & Programs

***How did you hear about our Practice? _____**

Your language preference: ☐English ☐Spanish ☐Russian ☐Vietnamese ☐other: _____

*Ethnicity: _____ * Race: _____ (Optional, CMS request)

Person responsible for bill or parent (*COMPLETE ONLY IF DIFFERENT FROM PATIENT*)

GUARANTOR NAME: _____ DOB:_____/____/_____ SSN: _____-____-_____

Relationship to Patient: ☐Spouse ☐Parent Other:_____ Phone: (_____)_____-_____

WHO TO CALL FOR AN EMERGENCY:

Name: _____ Primary Phone: (____)_____-_____ Relationship:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder Social Security Number: _____-_____-_____

Policy Holder Date of Birth: _____/ _____/ _____ Sex: M / F

SECOND INSURANCE:

Plan Name: _____ I.D. Number: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder Social Security Number: _____-_____-_____

Policy Holder Date of Birth: _____/ _____/ _____ Sex: M / F

*IS YOUR VISIT DUE TO A **JOB RELATED INJURY**, THIRD PARTY INJURY OR **AUTO ACCIDENT**? **Y_____ N _____***

CONSENT FOR SERVICES AND/OR DISCLOSURES OF PROTECTED HEALTH INFORMATION

I hereby consent to medical evaluation, testing and/or treatment provided to me by the staff of Rose Urgent Care and Family Practice. I also understand that Rose Urgent Care and Family Practice may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. Use of my email address for communication is permitted unless marked "NO" in the section above. I authorize release of any information concerning me (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the practitioner and agree to pay any remaining balance once my Insurance Plan has processed my claim.

_____ _____

Signature of patient or parent/guardian if minor *Date*

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Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

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Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Permission to Discuss and Share Healthcare Information

As a patient of Rose Urgent Care and Family Practice, there may be times when there is a need to share your health care information with others involved in your care. We cannot discuss any medical information with family or friends without your approval. Please provide the name(s) of the individual(s) who have permission to discuss and share your healthcare information. You may change, update, or revoke this form at any time.

I give permission to discuss my health care with the following individual(s):

NAME	RELATIONSHIP	TELEPHONE

☐ **I give permission to Rose Urgent Care and Family Practice to leave detailed voicemail regarding my health care at my personal phone number kept on file.**

I understand health care information may be discussed with the above noted individuals. Some of that information could include my prognosis or diagnosis, problem list, treatment plan, medications, diagnostic tests, discharge instructions and any other relevant medical information. This release does not cover information related to HIV Infection, AIDS, STD/STI, Mental Health, Drugs or Alcohol diagnosis unless you check and initial in the space below.

I do/Initial	I do not/Initial	Authorize the release of information related to:
☐____	☐____	HIV Infection, AIDS, Other Sexually Transmitted Diseases/Infections, and Sexual Health
☐____	☐____	Mental and Behavioral Health Information/Records
☐____	☐____	Drug/Alcohol Diagnosis, treatment and/or referral information

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or Psychological Care, and/or HIV/AIDS Records Release:
I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or other sensitive information. I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records (such as from Center for Addictions) that those records are protected by Federal Law. The Authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ **I decline to have any of my medical information discussed with family or friends.**

Print Name of Patient: _____

Signature of Patient: _____ **Today's Date:** _____

This form is good for one year from the date listed above, or you may list an alternate permission **End Date:** _____

ROSE URGENT CARE AND FAMILY PRACTICE

Privacy Practices Acknowledgment and Consent

I understand that Rose Urgent Care and Family Practice (referred to below as "This Practice) will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that This Practice may use and disclose my health information in order to:

- Make decisions about and plan for care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan and insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange and be reimbursed for quality cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice and my rights regarding my health information.

I understand that the Notice of Privacy Practice may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices, which will be provided at my request. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting room/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

By:_____ Date:_____
(Patient)

By:_____ Date:_____
(Patient representative)
Description of Representative Authority:_____

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Rose Urgent Care and Family Practice
Cancellation, No Show and Late Arrival Policy

Your providers here at Rose Urgent Care and Family Practice want to make sure that you have access to high-quality health care when you need it. To ensure maximum access for all of our patients, please be aware of the following appointment policy:

Scheduled Appointments:

If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know. This allows us enough time to offer your appointment to another patient. Failure to provide at least 24 hours' notice counts as a missed (no show) appointment. Also, depending on your insurance plan, we will bill you a missed appointment charge of $25.00 (Twenty-five dollars).

Missed Appointments/No Show:

Missed appointments/No Show will be documented in your record with each No-Show letter mailed to you. If you've missed three appointments, you will no longer be able to schedule appointment for routine care until you have met with our Care Coordinator. You will only be allowed to schedule Same Day appointments. Upon Care Coordinator's assessment and approval, you will be able to schedule additional appointments with your provider and/or will be discharged from future care.

Late Arrivals:

We require each established patient to arrive 15 minutes prior to their appointment time to allow for registration and vital sign checks. Patient will be considered late if arriving at scheduled time and will be given one of the following directives:

1) We may reschedule the appointment
2) We may try to work you in between patients to be seen for your most urgent need. We will schedule another appointment at a later date to permit the patient to receive the full value of their time with the provider.

If you have any questions about the Cancellation, No Show and Late Arrival Policy, please feel free to speak to any member of our staff.

I understand and agree to abide by this Cancellation, No Show and Late Arrival Policy.

Patient Name _____Patient Signature_____ Date _____

_____
Parent/Guardian Name (for patients under 18 years of age)

ROSE URGENT CARE AND FAMILY PRACTICE

Narcotic prescribing policy

Thank you for choosing Rose Urgent Care and Family Practice for your health care needs. Our primary concern is that you receive the most appropriate treatment to restore and maintain good health.

It is important that you read this prescribing policy. To be treated by a provider you must understand, agree to, and initial the provisions below.

_____The providers and staff at Rose Medical Groups are here to help patient's reach the following goal when treating pain: decreasing pain and improving function. Due to strong evidence supporting lack of benefit and increased chances of addiction and overdose, we do not prescribe opiates for long-term pain management. Evidence shows that there is similar benefit from short-term use of anti-inflammatories like Advil when compared to opiates, with no addiction, tolerance, or hyperalgesia. This is when a patient's pain increases because their body becomes more sensitive to pain the longer they use opiates like Vicodin, Percocet and OxyContin.

_____For patients with terminal medical conditions like end stage cancer, hospice will manage pain for the patient. For patients who just had surgery, the surgeon will manage pain for the patient.

_____This clinic also follows evidence-based practice by not prescribing other addictive medications such as benzodiazepines (Xanax, Ativan, Klonopin) or hypnotic medications (Ambien) for anxiety or sleep.

_____Stimulant medication prescribing for ADHD requires a mental health evaluation and diagnosis from a licensed mental health practitioner within the last 12 months. This documentation is required prior to prescribing medications. Minimum yearly re-evaluation is also required for continued prescribing of stimulant medications.

_____Stimulant medications will not be prescribed for weight loss. We can help you reach your goals by discussing appropriate options such as diet and exercise.

_____Patients requesting refills or new prescriptions for any of these medications will be counseled and provided clinically supported alternatives. Since these are addictive drugs with potential for harm, patients who are currently on daily narcotic medications will be medically titrated down as appropriate or referred for treatment. Drug testing is required prior to prescribing and may be requested at any time during the titration period at patient's cost if not covered by insurance.

ROSE URGENT CARE AND FAMILY PRACTICE

Reasons narcotic prescriptions may be immediately discontinued

-Evidence of prescription alteration, fraud, or solid evidence presented to our clinic that the patient has been selling or sharing medication with others.

-Any type of coercion including threats of legal action or violence made against any of our staff in order to obtain medications.

-Impairment of the patient to such a degree that, in the opinion of our medical practice, the patient poses a risk to themselves or to others.

-A drug screen inconsistent with the patient's history of prescribed medication or positive for other drug use, including marijuana and alcohol.

We appreciate your trust in us and thank you for the opportunity to serve your health care needs. If you have any questions about this policy, please speak with your provider or practice manager.

I, _____ HAVE READ AND UNDERSTAND THE PRESCRIBING POLICY ABOVE.
Please Print Name

_____ _____
Responsible Party (Signature) Date