Patient Medical History

Timothy B. Richards MD, FACS

Last:_________________________ **First:**_____________________ **MI:**_____ **Nickname:**_____________

SSI#:_________________________ **DOB:**_____________________

Address: St:___________________________________ **City:**_____________________ **ZIP:**__________

Below is required by the Federal ACA

Race:______________ **Preferred Language:**_________________ **Ethnicity:**__________________

Primary Care Physician:____________________ **Referring Physician (if different):**________________

Home Phone:__________________ **Cell Phone:** ________________ **Email:**______________________

PRIMARY INSURANCE: check if insurance card is presented and skip to next section: ☐

Name of Insurance Company:________________________________ **Policy #**_____________________

Name of Insured:____**Group#**_____________________

Address of Insurance Company:_____________________________ **Copay Amt:**_________________

City, State ZIP____ **Deductible:**_________________

Relationship to Patient: (Circle one) Self Spouse Partner Parent Other:______________________

Effective Date of Insurance:_____________________ **Expiration Date:**____________________

REASON FOR VISIT:_____________________________________

MEDICATIONS: Use back if more room needed

NAME	Strength	Dose
____________________	_______	_____________
____________________	_______	_____________
____________________	_______	_____________
____________________	_______	_____________
____________________	_______	_____________

ALLERGIES: Please list any of medications that you are allergic to

___________________________ ___________________________________

___________________________ ___________________________________

___________________________ ___________________________________

Rocky Mountain SURGICAL SOLUTIONS

MEDICAL AND SURGICAL HISTORY

Last Name:___________________________ First Name:___________________ DOB:_________

Medical

Onset year

◊ Allergies
◊ Anemia
◊ Angina
◊ Anxiety
◊ Arthritis
◊ Bleeding disorder
◊ Blood clots
◊ Cancer
◊ Cardiac arrest
◊ Cardiac arrhythmia
◊ Cardiac valvular disease
◊ COPD
◊ Coronary artery disease

Onset year

◊ Cohn's Disease
◊ Deep Vein thrombosis
◊ Dementia
◊ Depression
◊ Diabetes
◊ Elevated lipids
◊ Endocarditis
◊ Gallbladder disease
◊ GERD
◊ Headache, migraine
◊ Hepatitis/live disease
◊ Hypertension
◊ Inflammatory bowel
◊ Malignant hyperthermia
◊ MRSA

Onset year

◊ Myocardial infarction
◊ Osteoporosis
◊ Peptic Ulcer disease
◊ Pulmonary fibrosis
◊ Renal disease
◊ Seizure disorder
◊ Sleep apnea
◊ Stroke
◊ Thyroid disease
◊ VRE
◊ ◊ OTHER

____
____
____

Surgical

YEAR

◊ Angioplasty
◊ Appendectomy
◊ Arthroscopy
◊ Back Surgery

____

◊ Blood transfusion
◊ CABG
◊ Cardiac pacemaker
◊ Carpal tunnel release
◊ Cholecystectomy
◊ Colectomy

YEAR

◊ Gastric Bypass
◊ Gender reassign
◊ Hemorrhoidectomy
◊ Hernia Repair

____

◊ Hip replacement
◊ Knee replacement
◊ Liver biopsy
◊ Nephrectomy
◊ Organ transplant
◊ ORIF

YEAR

◊ Prostate biopsy
◊ Radiation therapy
◊ Thyroidectomy
◊ Tonsillectomy
◊ Valve replacement
◊ OTHER

____
____
____

FAMILY HISTORY:

RELATIONSHIP(Parents, siblings, children)

____
____
____

Medical History (diabetes, cancer, etc)

____
____
____

SOCIAL HISTORY

	Yes/no/former	Daily usage	How long	Age quit	Type (wine,beer,soda,coffee,etc)
Cigarettes/Cigar					
Chewing Tobacco					
Alcohol					
Caffeine					

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HEALTH HISTORY CONTINUED

Check symptoms you CURRENTLY have or have had IN THE PAST YEAR

Constitutional
- Chills
- Fatigue
- Fever
- Night Sweats
- Weight Gain
  How much?_____
- Weight Loss
  How much?_____

HEENT
- Ear drainage
- Hearing Loss
- Ear pain
- Sore throat
- Eye pain

Respiratory
- Chronic cough
- Shortness of breath
- Wheezing

Cardiovascular
- Chest pain
- Swelling in legs
- Palpitations
- Pass out, fainting
- Varicose veins

Gastrointestinal
- Abdominal pain
- Blood in stools
- Change in stools
- Constipation
- Loss of appetite
- Diarrhea
- Heartburn
- Nausea
- Vomiting

Genitourinary
- Pain while urinating
- Frequent urination
- Blood in urine
- Frequent urinating at night
- Urgency to urinate
- Incontinence

Increased frequency Endocrine
- Cold Intolerance
- Hot Intolerance

Neurological
- Dizziness
- Headaches
- Memory Impairment
- Seizures
- Tremors

Psychiatric
- Depression
- Anxiety

Skin and Breast
- Mole Changes
- Itching
- Rashes
- Breast discharge
- Breast lump

Musculoskeletal
- Back pain
- Bone/Joint pain
- Neck stiffness

Neck pain Blood and Lymphatic
- Easy bleeding
- Easy bruising
- Swollen lymph nodes

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if there is a change in health.

____ ____________________

Signature of Patient, Guardian or Personal Representative Date

____ ____________________

Physician Reviewed Date

Rocky Mountain SURGICAL SOLUTIONS

CONSENT FOR PURPOSES OF TREATMENT & HEALTHCARE OPERATIONS

I consent to the use of disclosure health information by Rocky Mountain Surgical Solutions for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care or to conduct healthcare operations of RMSS. I understand that diagnosis or treatment of me or Dr. Richards, MD, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. RMSS is not required to agree to the restrictions that I may request. However, if RMSS agrees to a request, the restrictions are binding on RMSS and Dr. Richards, MD.

I have the right to revoke this consent in writing at any time, except to the extent that RMSS, Dr. Richards, MD has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me; where there is a reasonable basis to believe the information may identify me.

I understand I have the right to review RMSS's Notice of Privacy Practices prior to signing this document. RMSS's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of m protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations at RMSS. The Notice of Privacy Practices for RMSS is also provided in the office waiting room. This notice of Privacy Practices also describes my rights and RMSS's duties to respect my protected health information.

RMSS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice before the visit. Visits may be rescheduled, or the patient may be financially responsible due to the lack of referral.

____ ______________

Signature of Patient/Legal Guardian **Date**

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

RMSS will not discuss or disclose confidential patient information unless permission is given by the patient. If you would like significant others to have the ability to discuss your care/information with us, please write their names and relationship to you below. I authorize the release of confidential information by Rocky Mountain Surgical Solutions to the following.

Name:____ **Relationship:**_________________________

Name:____ **Relationship:**_________________________

Name:____ **Relationship:**_________________________

Any restrictions or limitations for these releases? (Please specify) ____

If no limitations or restrictions for the above individuals please check the box ☐

Name:____ **Date:**_____________________________

Non-Insured Patients

-All office procedures are to be paid in full at the time of service. If you are unable to pay in full, prior to your appointment, you will need to speak with the office manager.

Third Party Claims

-Motor vehicle and private property claims are handled the same as our Non-insured patients.

Proof of Insurance

-We require proof of insurance in the form of an insurance card.

Insured Patients

-All co-payments, deductibles & co-insurances are collected at the time of service. This obligation is with your insurance company. Failure to do so is considered fraud. **Our office policy does not allow credit/debit cards payments for less than $10.**

Workers' Compensation

-It is the responsibility of the patient to notify our office with your claim number and case manager.

Child Custody

-RMSS will bill the insurance for one or both parents. However, the parent that signs for services is responsible for all outstanding balances. If you are no the legal guardian, treatment may be delayed until legal documentation can be obtained. No child under age 18 will be treated without a parent or legal guardian present.

Fees

-Our fees for service are based upon the Resource Based Relative Value scale and the Relative Value Units. These are both assigned by the Federal Government Medicare and Medicaid.

Insurance

-Our office will submit primary and secondary insurance claims for you if you have given us current insurance information. Please note that policy coverage varies so please check your insurance prior to your appointment. Our contractual agreement is with you not your insurance company. If there is a dispute related to the services provided or the charge for that service, it is between you and your insurance company. It is your Responsibility to remit payment for services not covered and to insure that your insurance company remits payments to our office.

No Show/Late fees

-A no show patient who fails to present themselves for a scheduled appointment three times is considered a chronic no show and will be dismissed from RMSS.

COLLECTION/PAYMENT POLICY

-Our office participates with numerous insurance companies and managed health care programs. Our billing office will submit a claim for services rendered for patients who are members of one of these plans after the patient has completed all necessary insurance information forms.

-It is the patient's responsibility to provide our office with current insurance information and to bring their insurance card to each visit.

-Our staff will help with questions related to insurance claims. Specific coverage questions must be addressed to your insurance company's service department

-It is the patient's responsibility to pay any deductible, co-insurance, co-payment or any portion of the charges as specified by the plan at the time of the visit. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment is due at the time of service.

*****Cash, Check, Debit payment, MasterCard or Visa are accepted*****

-RMSS's will send the patient at least two billing statements, if no payment is received the next statement is a pre-collection letter. If no payment has been received after this, your account will be turned over to our collection agency.

-If financial assistance is required, please notify the practice manager before seeing the physician. If no insurance is presented at time of service, payment will be expected unless prior arrangements have been made.

-If a payment plan is requested, upon approval, an interest rate of 10% will be applied to any outstanding balances.

-I understand that in the event any unpaid balance is placed for collections with a collections agency, a fee of 33% of the unpaid balance will be added to the total amount due and the delinquent balance will be reported on your credit report. This amount shall be in addition to any other costs incurred directly or indirectly to collect the unpaid balance, such as court costs, and attorney fees. The 33% fee represents what it costs RMSS to collect the unpaid balance.

I have read and understand the above RMSS Financial Policies

____

Signature of Patient/Legal Guardian

____

Date