ROCK RIDGE FAMILY MEDICINE

PATIENT INFORMATION:

Name: ____Birthday ______________________

Address: ___________________________________ City: _________________ Zip: _______________________

Phone: (Home)___________________ (Cell) __________________________ (Work) _______________________

Social Security Number: ___________________ Employer: ____

Email: _____________________________________

Gender (circle one):	Male	Female		
Ethnicity (circle one):	Hispanic	Non-Hispanic		
Race (circle one):	Asian White	American Indian Pacific Islander	Black/African American Hawaiian	Hispanic/Latino Other

EMERGENCY CONTACT INFORMATION:

Name: ____ Phone number: __________________________________

Relationship to Patient: ____

INSURANCE INFORMATION:

Primary Insurance: ___________________Subscriber's name: ____

Subscriber's SS#____________________________________ Birthdate_______________________________________

Secondary Insurance: ________________Subscriber's name: ____

Subscriber's SS#___________________________________Birthdate_______________________________________

_____I hereby assign payment directly to RRFM for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed indebtedness to RRFM for those services.

_____ I hereby authorize RRFM to release any information acquired in the course of my examination or treatment to my referring doctor and/or my insurance company or employer.

_____ I understand that RRFM providers have the right to refuse to see a patient and will refer you to seek other medical care if there is a patient balance of $300 or greater and/or payments have not been made in 3 months.

Signature____Date____________________________________

Rock Ridge Family Medicine

Regular attendance is an important aspect of successful treatment. Below is Rock Ridge Family Medicine's policy of "**missed appointments** "and a description of how this will be applied.

The definition of a missed appointment is when a client fails to keep an appointment with less than 24 hours cancellation notice. We **require** 24 hours notice when rescheduling any appointment. Cancellations and no shows are subjected to a fee of **$25.00**. **Insurance will NOT be billed for No Show.** The missed appointment fee will need to be paid prior to the appointment being rescheduled. A total of 3 missed/cancelled appointments will result in automatic termination from Rock Ridge Family Medicine. It is important that you are on time to each appointment to ensure that every patient can be seen in a timely manner. When you are late, you are making everyone else wait. Please be courteous and prompt. We appreciate your business.

Signature: ___________________________ Date:____________________________

Notice of Privacy Practices for Protected Health Information

Only as otherwise required by law or with your written authorization, you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights".

Patient Record of Disclosure

In general, the HIPAA privacy law, give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means; Such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: ___Ok to leave message with detailed information
___Leave a message with call back number only
Written Communications____ Ok to mail my home address
_____Ok to mail to my work/office address
_____Ok to fax to this number

My insurance information may be discussed with. The following individuals:

Name and Relationship:________________________Name and Relationship: __________________________

My protected health information may be discussed with the following individuals:

Name and Relationship:________________________Name and Relationship:___________________________

Signature: ____ Date:_________________________

Name: ______________________________

HEALTH HISTORY FORM

PHARMACY: ____

Current Medications**:** (**name of medication, dosage and how often it is taken**)

____

____

____

____

Allergies or intolerance to medications (**include type of reaction**):

____

____

HEALTH MAINTENANCE SCREENING TESTS:

Routine Physical Exam	Date_______________			
Sigmoidoscopy or colonoscopy (circle one)	Date ______________	Polyp?	○ Yes	○ No
Endoscopy (EGD)	Date ______________	Abnormal?	○ Yes	○ No

***Men only*:**

Prostate or PSA	Date ______________	Abnormal?	○ Yes	○ No
Routine Physical Exam	Date_______________			

***Women only*:**

Mammogram	Date ______________	Abnormal?	○ Yes	○ No
Pap Smear	Date ______________	Abnormal?	○ Yes	○ No
Bone Density Test	Date ______________	Abnormal?	○ Yes	○ No

WOMEN'S HEALTH HISTORY:

Total number of pregnancies: __________

Number of births: __________

Age at beginning of periods (menstruation): __________

Age at end of periods (menopause): __________

MEDICAL HISTORY: Please check (√) if you have had or currently have the following condition(s). Please abbreviate on family history as such: mother (M), father (F), brother (B), sister (S), maternal grandmother (MGM), maternal grandfather (MGF), paternal grandmother (PGM) or paternal grandfather (PGF).

Condition	**You (Past)**	**You (Current)**	**Family**	**Comments**
Alcohol Abuse				
Drug Abuse				
Anemia				
Anxiety				
Arthritis (Osteoarthritis)				
Arthritis (Rheumatoid)				
Asthma				
Blood Clot				
Breast Lump (Non-Cancerous)				
Cancer (Breast)				
Cancer (Colon)				
Cancer (Ovarian)				
Cancer (Prostate)				
Cancer (Skin)				
Cancer (Other)				Type?
Cataracts				
Chicken Pox				
Colon Polyp				
Coronary Artery Disease				
Depression				
Diabetes				
Diverticulitis/Diverticulosis				
Emphysema				
Fractures				Where?
Gallbladder Disease				
GERD/Heartburn				
Glaucoma				
Gout				
GYN Condition (Endometriosis)				
GYN Condition (Fibroids)				
GYN Condition (Other)				
Heart Attack				
Hepatitis A				
Hepatitis B				
Hepatitis C				
High Blood Pressure				
High Cholesterol				
Irritable Bowel Syndrome				
Kidney Disease/Failure				
Kidney Stones				
Liver Disease				
Migraine Headaches				
Osteoporosis				

Pneumonia				
Prostate Enlargement				
Prostate Nodules				
Seizure/Epilepsy				
Skin Condition (Eczema)				
Skin Condition (Psoriasis)				
Skin Condition (Other)				
Sleep Apnea				
Stomach Ulcer				
Stroke				
Thyroid Nodule				
Thyroid (Hyperthyroidism)				
Thyroid (Hypothyroidism)				
Other				

SURGICAL HISTORY: Please check (√) and date any procedure/surgery; list any abnormal findings or complications.

Surgical Procedure	Year	Comments
Abdominal Surgery		
Appendix Removal		
Biopsy		Location?
Breast Surgery		Circle: Right Left Both
Carpal Tunnel Release		Circle: Right Left Both
Cesarean Section		
Colon/Gastric Surgery		
Cataract		
Gallbladder Removal		Laparoscopic?
Heart Surgery/Bypass/Stent		
Hip Surgery		Circle: Right Left Both
Hysterectomy (Total, including ovaries)		Circle: Laparoscopic Vaginal Abdominal
Hysterectomy (Partial, ovaries left)		Circle: Laparoscopic Vaginal Abdominal
Knee Surgery		Circle: Right Left Both
LEEP (Cervix Surgery)		
Ovary Ligation ("Tubal")		
Ovary Removal		Circle: Right Left Both
Vasectomy		
Shoulder Surgery		Circle: Right Left Both
Sinus Surgery		
Spine Surgery (cervical/thoracic/lumbar)		Circle: Cervical Thoracic Lumbar
Tonsillectomy		
Wisdom Tooth Extraction		
Other		

TOBACCO USE:

○ Never ○ Formerly ○ Currently ○ Smokeless Tobacco

Former User

Quit Date: ____________ Years of usage? _________

Approximate amount of daily usage? ___________

Current User

Daily Use: ___________ Years of usage? ___________

ALCOHOL USE:

Do you drink alcohol? ○ No ○ Yes

Number of drinks per week: _______ ○ Beer ○ Wine ○ Liquor

DRUG USE:

Do you use recreational drugs? ○ No ○ Yes

Have you ever used needles to inject drugs? ○ No ○ Yes

SEXUAL ACTIVITY:

Sexually involved currently? ○ No ○ Yes

Sexual partners is/are/have been: ○ Male ○ Female

Birth control method (circle all that apply): condom, pill, diaphragm, vasectomy, none, other _______

EXERCISE:

Do you exercise regularly? ○ No ○ Yes

What kind of exercise? ____

How long (minutes)? _________________ How often? ____________________

SOCIAL HISTORY:

Are you currently (circle one): employed full-time, employed part-time, unemployed, disabled, retired, on leave of absence

Occupation (or prior occupation): ____

Employer: ____

Year of education or highest degree: ____

Marital Status (circle one): single, partner, married, divorced, widowed

Spouse/Partner's name: ___________________________ Number of children: ___________

Who lives at home with you? ____

Have you completed (circle all that apply): Advance Directive for Health Care, Living Will or Physician Order for Life Sustaining Therapy? If not, would you like to? ○ No ○ Yes

Leisure Activities, group involvement, religion, volunteer work, recent travel:

____

____

____

Controlled and Opioid Medication Agreement 2019

The long term use of opioid therapy is somewhat controversial because of uncertainty regarding the extent to which this treatment actually improves the quality of lives of those receiving it. There is the potential risk of development of an addictive disorder or of relapse occurring in a person with a prior addictive disorder. The extent of this risk is not certain. These medications have potential for abuse or diversion and, accordingly, rather strict accountability is necessary when use is prolonged.

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management, as well as other conditions requiring use of controlled substances. This is to help both you and your doctor to comply with laws regarding controlled pharmaceuticals.

Please initial the following after reading:
____I understand that if I break this agreement, my doctor will stop prescribing these medications. In this case, my doctor will taper me off of the medication over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug- dependence treatment program may be recommended.

____I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life and how well the medicine is helping to relieve the pain.

____I will not use any illegal controlled substances, including methamphetamine, cocaine, etc. I also agree to not use alcohol while on controlled medicines due to the potential adverse effects that the combination can cause.

____I will not share, sell or trade my medications with anyone including my family and friends.

____I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or ant-anxiety medicines from any other doctor. If controlled medications are given to me through an ER or minor emergency center, a surgeon or other specialist, it is my responsibility to notify Dr. Wolff's office within 24 hours of receiving these medications.

____I will safeguard my controlled medicines from loss of theft. Medications will not be replaced if they are lost, fall in the toilet, are eaten by pets, left on an airplane, or for any other reason. I understand that stolen medications will need a police report filed. I agree to notify the doctor within 24 hours of my medication being lost or stolen.

____I agree that refills of my prescriptions for controlled medicines will be done only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends. I understand that I will need to be seen every 30 days for refills and that no exceptions will be made to the rule.

____I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my medicine. I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

____I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance. If my insurance does not cover the expense of these random screenings, I understand that I will be responsible for the cost out of pocket.

____I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. I understand that my medicine will not be filled early due to my noncompliance of the prescribed dosing. If I feel that I need to take more medication than I am prescribed. I understand that I need to call and make an appointment to discuss these changes. I understand by not having the approval of the doctor in these changes, I am breaking my agreement.

____I will bring all unused controlled medicines to every office visit to ensure proper usage.

____I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been offered.

____I understand that there are risks to the long term use of controlled medications and take full responsibly to the use of them.

I agree to use____________________ pharmacy, located at ____________________________ with telephone number _____________________, for filling prescriptions for all of my controlled medications. If this changes, I will notify Rock Ridge Family Medicine immediately.

This agreement is entered on this _______day of ________________________, ___________

Printed Name:____

Patient Signature: ____

Provider Signature: ____

Witness Signature: ____

Authorization for Disclosure of Health of Information

Patient Name:_______________________________________ Date of Birth:_______________________

1. I authorize the use of disclosure of the above named individual's health and financial information for continuity and or cooperative healthcare.
2. The following individual or organization is authorized to make the disclosure:

   (PREVIOUS DOCTOR)

   Name:__________________________ Phone:________________

   Address:____

   City:____________________ State:___________ Zip:_________

3. The type and amount of information to be used or disclosed is as follows (include dates where appropriate).

   ____Last Year Health Records

   ____Other ____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

   (Individual who wants records)

   Name: Rock Ridge Family Medicine Timothy Wolff DO

   Fax : 877-467-9656

   Address: 8010 E 53 N

   Bel Aire KS 67226

6. The purpose of this request is for:____
7. I understand that I have the right to revoke this release at anytime with written notification.
8. If I fail to specify an expiration date, event or condition, this authorization will expire in 1 year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. (I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.) If I have question about disclosure of my information, I can contact Rock Ridge Family Medicine.

Patient Signature:________________________________Date_______________________________________