River Rock Family Practice, PC was created with the idea that the patient should work in unison with their provider to optimize health and wellness. This practice was founded and is owned by Mason Harrison, a Certified Family Nurse Practitioner.

Family Nurse Practitioners provide the full spectrum of primary care. We treat acute illness and injury as well as manage chronic diseases such as diabetes, high blood pressure and hormone imbalance. Our goal is to treat the whole person, not just their list of symptoms. Working from this standpoint means we understand how both emotional and physical factors impact overall health. We encourage patients to take an active role in their health care so the provider and patient can work as a team to optimize overall health and wellbeing.

Here at River Rock Family Practice, we strive to provide the most effective healthcare to our patients and their needs. This packet will be a way for us to get obtain your pertinent health information and for us to get to know you, your health history, and your family.

Please take the time to complete your New Patient Packet in full, as an incomplete packet will delay our intake process.

- Print as clearly as possible to avoid transcription errors
- Use only Black or Blue ink (no pencils or gel pens please!)
- Once you are finished with your packet, please return it to our Front Desk for processing
- Be sure to bring your ID and Insurance Cards
- Allow up to 7 business days for our office to process your paperwork and call you for an appointment
- If you have any questions regarding this packet, please do not hesitate to call our office and speak with our front desk @ 541-226-9840 OPTION 1

We look forward to seeing you!

New Patient Paperwork

Welcome to River Rock Family Practice, and thank you for considering us to be your healthcare professionals. We are committed to providing the best, most comprehensive care possible. Please fill out this New Patient Questionnaire in full, an incomplete packet will delay our intake process.

Patient information:

Patient **First** Name: _____ M.I _____ Patient **Last** Name: _____

DOB: ____/____/_____ Age: _____ Gender: _____ Social Security Number: _____-_____-_____

Race: ☐ Decline ☐ White/Caucasian ☐American Indian/Alaska Native ☐Black/African American ☐Asian
☐Native Hawaiian/Pacific Islander ☐Other: _____

Ethnicity: ☐Declined ☐Hispanic or Latino ☐Not Hispanic or Latino

Is the patient under the age of 18? ☐ Yes ☐ No *If yes, please list parent/guardian information below ⇓

Name: _____ Phone Number: _____ Relationship to patient: _____

Name: _____ Phone Number: _____ Relationship to patient: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: (*if different from physical*) _____

City: _____ State: _____ Zip Code: _____

Contact Information:

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Other: _____

Preferred Method of Contact? ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

May we leave a voicemail? ☐ Yes ☐ No

Containing → ☐ Appointment Reminders ☐ Clinical Information ☐ Financial Information (Select all that apply)

Would you like an invite to our Patient Portal? ☐ Yes ☐ No

Patient information continued:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employment Status: ☐ Employed ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

*If employed, what is your occupation? _____

Who is your employer? _____

May we contact you at work? ☐ Yes ☐ No Work Phone: _____

Preferred Pharmacy: _____ Cross Street: _____

City: _____ State: _____

Emergency Contact 1:

First Name: _____ Last Name: _____

Phone Number: _____ Relationship to patient: _____

Emergency Contact 2:

First Name: _____ Last Name: _____

Phone Number: _____ Relationship to patient: _____

Insurance Information:

*Do you have health insurance? ☐ Yes ☐ No

*is your insurance Medicare or Medicaid/State? ☐ Yes ☐ No

Initial here: _____

Primary Insurance: _____

Subscriber/Member ID#: _____

Group #: _____

Claims Address: _____

City: _____ State: ____ Zip Code: _____

Are you the subscriber/policy holder? ☐ Yes ☐ No

*If no, who is the subscriber/policy holder?

Name: _____ DOB: _____

Relationship to patient: _____

Secondary Insurance: _____

Subscriber/Member ID#: _____

Group #: _____

Claims Address: _____

City: _____ State: ____ Zip Code: _____

Are you the subscriber/policy holder? ☐ Yes ☐ No

*If no, who is the subscriber/policy holder?

Name: _____ DOB: _____

Relationship to patient: _____

Health History Information

Please complete the following forms regarding your present and past medical history in full.
Incomplete forms can cause a delay in our intake process.

Medications/Prescriptions:

Please list all of your current medications, **including** over the counter, herbs and vitamins

☐ check here for NONE

Medication Name	Dosage	How often?

Allergies:

*Please check all that apply and list reaction to each allergy selected

	Allergy:	Reaction:		Allergy:	Reaction:		Allergy:	Reaction:
☐	NONE	N/A	☐	NKDA	N/A	☐	NKA	N/A
☐	Acetaminophen		☐	Adhesive Tape		☐	Antibiotic	
☐	Aspirin		☐	Corn		☐	Dairy	
☐	Egg		☐	Epinephrin		☐	Gluten	
☐	Ibuprofen		☐	Iodine		☐	Latex	
☐	Mercury		☐	Nuts		☐	NSAIDS	
☐	Opioids		☐	Penicillins		☐	Shell Fish	
☐	Statins		☐	Sulfa		☐	Tylenol	
☐	Wheat		☐	Other :		☐		
☐			☐			☐		
☐			☐			☐		

Health History Information

Please complete the following forms regarding your present and past medical history in full.
Incomplete forms can cause a delay in our intake process.

Past and Current Medical History:

(Check all that apply)

☐ Check here for **NONE**

☐ AIDS	☐ Diverticulitis	☐ Osteoporosis
☐ Anemia	☐ Dizziness	☐ Peptic Ulcer
☐ Anxiety Disorder	☐ Eczema	☐ Psoriasis
☐ Arthritis	☐ Esophageal Reflux	☐ PTSD
☐ Asthma	☐ Fibromyalgia	☐ Sleep Apnea
☐ Back Pain	☐ Gallstones	☐ Stroke
☐ Bipolar Disorder	☐ Hepatitis	☐ Thyroid Disorder
☐ Cardiac Arrest	☐ High Cholesterol	☐ Vomiting
☐ Chest Pain	☐ High Blood Pressure	☐
☐ COPD	☐ Insomnia	☐
☐ Chronic Pain Syndrome	☐ Kidney Disease	☐
☐ Deep Vein Thrombosis	☐ Liver Disease	☐
☐ Depression	☐ Migraines	☐
☐ Diabetes Type I	☐ Heart Attack (Myocardial Infarction)	☐
☐ Diabetes Type II	☐ Nausea	☐

Surgical History:

☐ Check here for **NONE**

Procedure:	Year	Procedure:	Year	Procedure:	Year	Procedure:	Year
☐ Appendectomy		☐ Blood Transfusion		☐ Mastectomy – Bilateral		☐ Tubal Ligation	
☐ Amputation		☐ Colonoscopy		☐ Mastectomy – Left Breast		☐	
☐ Back Surgery – Cervical		☐ C-Section		☐ Mastectomy – Right Breast		☐	
☐ Back Surgery - Lumbar		☐ Hernia Repair		☐ Melanoma Removal		☐	
☐ Back Surgery – Thoracic		☐ Hysterectomy		☐ PE Tubes		☐	
☐		☐		☐		☐	

Hospitalizations:

(admissions only)

Year/When?	Procedure/Why?	Hospital/Where?

Health History Information

Please complete the following forms regarding your present and past medical history in full.
Incomplete forms can cause a delay in our intake process.

Family Health History:

Please list your pertinent family history below. Be sure to specify how they are related to you, i.e.: mother, father, aunt, uncle etc…

☐ Check here for **NONE**

Condition:	Who?	Maternal or Paternal	Condition:	Who?	Maternal or Paternal
		☐ ☐			☐ ☐
		☐ ☐			☐ ☐
		☐ ☐			☐ ☐
		☐ ☐			☐ ☐
		☐ ☐			☐ ☐
		☐ ☐			☐ ☐
		☐ ☐			☐ ☐

Last Preventative Procedures/Exams:

	Never	0-6 months	6-12 months	1-4 years	5+ years
Blood Draw/ Labwork	☐	☐	☐	☐	☐
Colonoscopy	☐	☐	☐	☐	☐
Mammogram	☐	☐	☐	☐	☐
Physical Exam or Well Child Check	☐	☐	☐	☐	☐

Do you have a Will, POLST or Advanced Directive? ☐ Yes ☐ No

*if No, would you like more information? ☐ Yes ☐ No

Social History:

Smoking Status? ☐ Current, every day* ☐ Current, some days ☐ Never ☐ Former*

*when did you start? _____ *when did you quit? _____

How many cigarettes do you smoke per day on average? _____

PBM Consent

E- PRESCRIBING PBM CONSENT FORM

ePrescribing is defined as a physicians ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have been 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 prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that River Rock Family Practice can request and use your prescriptions medication history from other healthcare provider and/or third party pharmacy benefit payers for treatment purposes.

Check one:

☐ I accept

☐ I Decline

Name (Print): _____

Signature: _____ Date: _____
(patient)

OR

Signature: _____ Date: _____
(Patient Representative/Guardian)

Description of Representatives Authority: _____

Acknowledgment and Consent

I understand that River Rock Family Practice, P.C. (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 my 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 or 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 physicians efforts to prove me with, arrange and be reimbursed to 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 Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of this practice's Notice of Privacy Practices in effect will be posted in waiting/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 and that I have received a copy of the Notice of Privacy Practices.

Name (Print):_____

Signature: _____ Date: _____
(patient)

OR

Signature: _____ Date: _____
(Patient Representative/Guardian)

Description of Representatives Authority: _____

Financial Policy

The following disclosures are made in compliance with the Federal Truth in Lending Law. River Rock Family Practice, P.C will extend credit to a patient with the understanding that:

- **Parent/Child** – The adult accompanying the child is responsible for payment at the time of service including copayment. The Parent/guardian with whom the child reside is the person who will be billed for services rendered. We will not be involved in mediating financial arrangements between parents/guardians. We will bill insurance as stated below.
- **Regarding Insurance** – It is the responsibility of the patient to know what is covered and excluded from his/her plan. You will be asked to present your insurance card at each visit. If this information is not provided, the balance will be the patient's responsibility. We require that you pay your co-pay at the time of service. If this payments is not made by closing of the next business day a charge of $10.00 will be assessed. We accept all payments made from the insurance. If there is an overpayment made from either the patient or insurance company, there will be a refund generated.
- **Secondary Insurance** – We will submit claims to your secondary carrier as a courtesy. You are responsible for deductibles, co-pays, and any non covered services provided. You are responsible for any balance after insurance has cleared.
- **Unusual and Customary Rates** – Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.
- **Private Pay**- We require that our patients without insurance pay in full at the time of service. We offer a discount if fill payment is made on the day of service. All charges are due and payable within 30 days from the date of the closing statement. If there is no payment made at that time, the patient has 60 days to pay off the debit until a monthly fee of $5.00 is charged.
- **Monthly Payments and Outstanding Balances** – If you are not able to pay your account in full at the time of service and need to make monthly payments, you will need to make a payment arrangement with our billing office. After this arrangement is made, the account will be turned over to our collection agency if it is not met.
- **Service Charges** – We reserve the right to apply a billing charge of $5.00 per month to your account for balances after 60 days. A fee of $25.00 will be assessed to your account for any checks returned due to non-sufficient funds. We will charge the patient $5.00 for forms filled out by the provider if not done at the time of service. This is to cover additional administrative costs. If the patient does not give 24 hours notice of not being able to attend a scheduled appointment, a no show fee of $25.00 will be assessed. These amounts will not be billed to the insurance company. We accept personal checks, money orders, VISA, MasterCard and Cash.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to the Financial Policy of River Rock Family Practice, P.C.

_____ Date: _____

Signature of Responsible Party

_____ _____

Printed name of Responsible Party *Relationship to Responsible Party*

Mason Harrison, FNP-C

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

Patient name _____ Date of birth _____

Authorization

I authorize _____ Fax number _____
(Name and address of individual/entity releasing information)

to use and disclose a copy of the specific health information described below to: For the purpose of:

River Rock Family Practice, PC. Fax (541) 226-9846 ***Transfer of care***

By **initialing** the spaces below, I specifically authorize the release of the following medical records, if such records exist: Please **initial** for release of records (**do not *check* spaces**)

_____ ***Complete medical record***
_____ Laboratory reports/pathology reports
_____ Diagnostic imaging reports
_____ Most recent three (3) year history
_____ Physical therapy records
_____ Other (specify)_____
_____
_____
_____ This authorization is limited to the following treatment: _____
_____ This authorization is limited to the following time period: _____
_____ This authorization is limited to worker's comp claims for injuries of: _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS information
_____ Genetic testing information
_____ Sexually transmitted disease information
_____ Mental health information
_____ Sexually transmitted disease information
_____ Alcohol/chemical dependency diagnosis, treatment or referral info.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal law restricts redisclosure of alcohol and chemical dependency diagnosis, treatment or referral information and specifically requires my authorization prior to redisclosure.

Patient information

You do not need to sign this authorization. Refusal to sign will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to _____ (contact person) at _____ (address of person/entity disclosing information) and state you are revoking this authorization.

This authorization will expire on the earlier of _____ (date), 180 days from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Signature

I have read this authorization and I understand it.

_____ _____
(Signature of individual or personal representative) *(Date)*

Description of personal representative's authority

_____