Roaring Fork Surgical Assoc, Prof. LLC.
1906 Blake Avenue 4th Floor
Glenwood Springs, CO. 81601
(970) 945-6533 Office
(970 945-3945 Fax

Dear Patient

Please carefully review the enclosed information and complete the Patient Health History page and sign ALL enclosed paperwork. This information is very important for your surgery/procedure. Once you have read and signed all needed documents, please bring this packet with you to your visit.

Thank you,

Physicians & Staff

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures

Treatment

Your health information may be used by staff members or disclosed to other health professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to health professionals who may provide treatment or who may be consulted by staff members.

Payment

Your health information may be used to seek payment from your health plan, from sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided, and the medical condition being treated.

Health Care Operations.

Your health information may be used as necessary to support the day-to-day activities and management of Roaring Fork Surgical Associates, Prof. LLC**.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement.

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting.

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment Reminders.

Your health information will be used by our staff to telephone you in regards to future appointments.

Information about treatments.

You health information may be used to send you information on the treatment and management of you medical condition that you may find to be of interest, knowing that all such documents would be send via certified mail.

Other uses and disclosures require your authorization.

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of your information that occurred prior to notification.

Individual Rights.

You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information.

The right to receive confidential communication concerning your medical condition or treatment.

The right to inspect and have our office staff copy, on your behalf, your protected health information.

The right to amend or submit corrections to your protected health information.

The right to receive an accounting of how an to whom your protected health information has been disclosed not relating to treatment, payment, operations.

The right to receive a printed copy of this notice.

Request to inspect Protected health information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting either the Security Officer or Privacy Officer.

Roaring Fork Surgical Associates, Prof. LLC. Duties.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
Roaring Fork Surgical Assoc, Prof. LLC.
1906 Blake Ave. 4th Floor
Glenwood Springs, CO. 81601
(970) 945-6533 Office
(970) 945-3945 Fax

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices for Roaring Fork Surgical Assoc. Prof. LLC.

Name of Patient _____

Signature of Patient _____

Signature of Patient Representative _____

(Required if the patient is a minor or an adult who is unable to sign the form)

Relationship of Representative _____

Date _____

Roaring Fork Surgical Associates Professionals LLC.

Randall E. Ross, M.D. Brad Nichol, M.D.

Patient Information

Referring Physician _____ PCP Name (if not referred) _____

◯ Male ◯ Female

Last Name _____ First Name _____ MI ___ DOB _____ SSN _____

Physical Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Marital Status ◯ SIngle ◯ Married ◯ Divorced ◯ Widowed Spouses Name _____

Employer _____ Address _____ Phone Number _____

Emergency Contact _____ Phone Number _____ Relationship _____

Financial Responsibility

Last Name _____ First Name _____ MI ___ DOB _____ Relationship _____

Mailing Address _____ City _____ State _____ Zip _____

SSN _____ Home Phone _____ Mobile Phone _____

Employer _____ Address _____ Work Phone _____

Insurance Carrier Information

Primary Carrier _____

Group Name/Number _____

Insured Name _____ DOB _____

Policy/ID# _____ Phone Number _____

Secondary Carrier _____

Group Name/Number _____

Insured Name _____ DOB _____

Policy/ID# _____ Phone Number _____

Workman's Comp ◯ YES ◯ NO Claim # _____ Policy # _____

Authorization for treatment/release of information

I, the undersigned, knowing the patient is suffering from a condition requiring health care, diagnosis, and medical treatment, hereby voluntarily agree to such diagnostic procedures and health care services that may be administered to or performed on the patient under the instructions of the physician, his assistants or assignees. I authorize the release of medical information to my referring doctor, health agency, government agency or insurance company.

Financial policy

I, the undersigned, assume full responsibility for all medical charges incurred as a patient with Roaring Fork Surgical Associates, Prof, L.L.C.
Payment in full is due at the time the patient receives services or supplies unless specific arrangements are made in advance. If this account remains unpaid for over 60 days, it may be turned over to an attorney/collection agency for purposes of collecting the debt, in which event the undersigned agrees to be responsible for all costs incurred in collection for this account including reasonable attorney/collection fees with accrued interest at a rate of 18% per annum.

I authorize and request the insurance company to pay directly to Roaring Fork Surgical Associates, Prof, L.L.C the amount due me in my pending claim for Basic Medical, Major Medical, and/or Surgical treatment or services by reason of such treatment or services rendered to the patient.

I have read and understand the authorization for treatment/release of information and financial policy and agree to all the terms stated therein until such time as I deliver written notice to the contrary to Roaring Fork Surgical Associates, Prof, L.L.C.

Patients Signature _____ Date _____

Legal Guardian Signature _____ Date _____

Medical Information

PRESENT COMPLAINT

PRESENT ILLNESS

Family Member	Living	Dead	Cause of Death
Father	☐	☐	
Mother	☐	☐	
Brother/Sister	☐	☐	

FAMILY HISTORY

Has any blood relative ever had:

Cancer, Including Leukemia	◯ Yes	◯ No	Who
Tuberculosis	◯ Yes	◯ No	Who
Diabetis	◯ Yes	◯ No	Who
Heart Trouble	◯ Yes	◯ No	Who
Heart Attack	◯ Yes	◯ No	Who
High Blood Pressure	◯ Yes	◯ No	Who
Bleeding Disorder	◯ Yes	◯ No	Who

PERSONAL HISTORY

Weight loss in last year	◯ Yes	◯ No

ALLERGIES

Penecillin	◯ Yes	◯ No
Sulfa	◯ Yes	◯ No
Other Antibiotics	◯ Yes	◯ No
Do you smoke	◯ Yes	◯ No
Do you drink	◯ Yes	◯ No

CONTINUED FROM PREVIOUS PAGE

MEDICINES

Are you taking any medicines regularly now? ◯ Yes ◯ No

_____

_____

_____

_____

INSULIN	◯ Yes	◯ No	When _____
CORTISONE	◯ Yes	◯ No	When _____
THYROID MEDICINE	◯ Yes	◯ No	When _____
BLOOD PRESSURE MEDICINE	◯ Yes	◯ No	When _____
BIRTH CONTROL PILLS	◯ Yes	◯ No	When _____

Other _____

_____

_____

_____

OPERATIONS

Have you had any of these operated upon:

TONSILS	◯ Yes	◯ No	When _____
APPENDIX	◯ Yes	◯ No	When _____
GALL BLADDER	◯ Yes	◯ No	When _____
THYROID	◯ Yes	◯ No	When _____
HERNIA	◯ Yes	◯ No	When _____
BREAST	◯ Yes	◯ No	When _____
UTERUS	◯ Yes	◯ No	When _____
OVARIES	◯ Yes	◯ No	When _____

Other _____

_____

_____

_____

CONTINUED FROM PREVIOUS PAGE:

DIAGNOSED DIFFULTIES

Do you now, or have you in the past, had any of the following

LYMPHATIC SYSTEM	◯ Yes	◯ No
EYES	◯ Yes	◯ No
EARS	◯ Yes	◯ No
HEARING	◯ Yes	◯ No
NOSE	◯ Yes	◯ No
MOUTH-THROAT	◯ Yes	◯ No
NECK	◯ Yes	◯ No
HEART	◯ Yes	◯ No
LUNGS	◯ Yes	◯ No
BREASTS	◯ Yes	◯ No
ABDOMEN	◯ Yes	◯ No
RECTAL	◯ Yes	◯ No
HERNIA	◯ Yes	◯ No
GENITALIA	◯ Yes	◯ No
EXTREMITIES	◯ Yes	◯ No
SPINE	◯ Yes	◯ No
NERVOUS SYSTEM	◯ Yes	◯ No

Other Breast Disease _____

Times Pregnant _____

Number of Children _____

Miscarriages _____

Last Pap Smear _____

Patients Signature _____ Date _____

PHYSICIANS NOTES:

PLEASE DO NOT WRITE BELOW THIS LINE

PHYSICAL EXAM	NORMAL	ABNORMAL	DETAILS OF ABNORMAL FINDINGS
LYMPHATIC SYSTEM	☐	☐	
EYES	☐	☐	
EARS	☐	☐	
HEARING	☐	☐	
NOSE	☐	☐	
MOUTH-THROAT	☐	☐	
NECK	☐	☐	
HEART	☐	☐	
LUNGS	☐	☐	
BREASTS	☐	☐	
ABDOMEN	☐	☐	
RECTAL	☐	☐	
HERNIA	☐	☐	
GENITALIA	☐	☐	
EXTREMITIES	☐	☐	
SPINE	☐	☐	
NERVOUS SYSTEM	☐	☐	

Physician Signature _____ Date _____