Welcome to Rocky Mountain Primary Care!

Thank you for choosing Rocky Mountain Primary Care as your new provider. Our goal is to make every interaction you have with our office a pleasant experience.

Rocky Mountain Primary Care is Your Patient Centered Medical Home!

A Medical Home is not a place, but an approach to providing care for children, youth and adults. The Medical Home enables partnerships between individual patients and their personal primary care providers and when appropriate, the patient's family.

In a Medical Home, the practice is organized around the patient – communication is based on trust, respect and shared decision-making. Patients have access to personalized, coordinated and comprehensive primary care.

It is essential for all new patients/families to provide a complete medical history when establishing care with us, and to share any information about care received outside of our office (hospitals, specialists, etc.). Please complete enclosed New Patient Packet and bring with you to your first visit at with your new provider at RMPC.

WHAT YOU CAN EXPECT FROM YOUR CARE TEAM AT RMPC:

- A safe environment to talk about your concerns
- Responses to your questions and concerns at each appointment
- Partnering with you, using shared decision making, to help you manage your health care
- Being the "Quarterback" on your health care team, coordinating care with our office and specialists you see

WHAT YOUR CARE TEAM AT RMPC EXPECTS OF YOU:

- Be an active participant on your health care team
- Bring your list of questions and medications to each appointment
- Bring your Photo ID, Insurance Card, and Co-Pay to every visit
- Call our office before going to the emergency room or hospital – we can usually get you into the office the same-day when appropriate, and we always have a physician available on call after hours
- Inform other providers you may see that RMPC is your Primary Care Provider, and ask them to share with us information regarding the care they provided you.

Please bring the following items to your first visit:

❑ Photo ID ❑ Insurance card ❑ Co-pay	Forms (included in this packet): ❑ New Patient Demographic Form ❑ New Patient History Form ❑ Patient's Authorized Contacts ❑ Patient Portal Sign-Up Form ❑ Privacy Practices Acknowledgement

Rocky Mountain Primary Care **Patient Demographic Form**

Who is your RMPC Doctor: _____

Last Name:	First Name:	MI:
Sex: M F	Birthdate:	SSN:
Street Address:		
City:	State:	Zip:
Home:	Work:	Cell:
Preferred Contact: ❑ Home ❑ Work ❑ Cell		
Preferred Language:		

Race:
- ❑ American Indian /Alaska Native
- ❑ Black /African American
- ❑ Other Pacific Islander
- ❑ White /Caucasian
- ❑ Asian
- ❑ Native Hawaiian
- ❑ More than one race
- ❑ Other
- ❑ Unreported/Refuse to Report

Ethnicity:
- ❑ Hispanic or Latino
- ❑ Non-Hispanic
- ❑ Refuse to Report
- ❑ Unreported/Refuse to Report

Marital Status:
- ❑ Single
- ❑ Married
- ❑ Divorced
- ❑ Separated
- ❑ Widowed

OTHER FAMILY MEMBERS SEEN BY OUR PRACTICE

	Relationship	Same Insurance?
1.		Y N
2.		Y N
3.		Y N
4.		Y N

RESPONSIBLE PARTY (*if different from patient*):

Last Name _____ First Name _____ MI _____

Sex M F Birthdate _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____ ID Number _____

_____ Group Number _____

Effective Date _____

POLICY HOLDER (*if different from patient*):

Last Name _____ First Name _____ MI _____

Sex M F Birthdate _____ SSN _____

Employer _____ Phone _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: *I hereby authorize payment directly to Rocky Mountain Primary Care, P.C., the surgical and/or medical benefits available, if any, and authorize release of any medical information necessary to process this and future claims. I understand that if my insurance fails to make a payment, I am ultimately responsible for payment of services rendered.*

Patient / Guardian Signature: _____ Date: _____

Name: _____ Birthdate: _____ Today's Date:_____

DO YOU HAVE SECONDARY INSURANCE? ❑ YES ❑ NO

IF YES, SECONDARY INSURANCE INFORMATION

Insurance Company _____ Phone _____
Address _____ ID Number _____
_____ Group Number _____
Effective Date _____

POLICY HOLDER (if different from patient):

Last Name _____ First Name _____ MI _____
Sex M F Birthdate _____ SSN _____
Employer _____ Phone _____

IS YOUR VISIT ACCIDENT RELATED? ❑ YES ❑ NO

If yes, what type of accident? ❑ Auto ❑ Work ❑ Other _____
Date of Accident _____ Case / Claim Number _____
Adjuster's Name _____ Phone Number _____
If work related, has employer been notified? ❑ Yes ❑ No
If yes, employer contact _____ Phone _____

Rocky Mountain Primary Care **Pediatric New Patient History Form**

Name: _____ Today's Date: _____

Birthdate: _____ Primary Care Provider (PCP): _____

Please list any allergies your child has and their reaction (include drug and food allergies):

Allergy	Reaction

Please list medications your child currently takes (including over the counter medications):

Medication Name	Dose (mg)	How often

Please list the date your child had the following immunizations:

❑ *Immunization Card Provided*

Vaccination	Dose #1	Dose #2	Dose #3	Dose #4	Dose #5
Hepatitis B					
DTaP/DTP/DT					
Hib					
Polio					
PCV7					
PPV23					
MMR					
Varicella					
Flu					
MCV4/MPSV4					
Td					
Tdap					
Hepatitis A					
Rotavirus					
HPV					

Name: _____ Birthdate: _____ Today's Date:_____

PAST MEDICAL HISTORY

Please list any significant problems your child has had:

Problem		Year	Problem		Year
❑ Yes	Allergies		❑ Yes	Scarlet Fever	
❑ Yes	Asthma		❑ Yes	Measles	
❑ Yes	Diabetes		❑ Yes	Mumps	
❑ Yes	Heart problems		❑ Yes	German Measles	
❑ Yes	Kidney problems		❑ Yes	Blind	
❑ Yes	Liver problems		❑ Yes	Deaf	
❑ Yes	Pneumonia		❑ Yes	Developmental Delay	
❑ Yes	Seizures		❑ Yes	Autism	
❑ Yes	Chickenpox		❑ Yes	Cerebral Palsy	
❑ Yes	Rheumatic Fever				
❑ Yes	Turner's Syndrome				
❑ Yes	Down Syndrome				

Has your child ever had a hospitalization, surgery, or serious injury?

Year	Reason	Hospital

If your child has seen any specialists for any conditions, please list below:

Specialist Name	Seen For	When

FAMILY MEDICAL HISTORY

Family History	Mother		Father		Brother / Sister		Brother / Sister		Brother / Sister		Brother / Sister		Other		Other	
Still Living?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
If not, cause of death?																
Age at death?																
Diabetes																
Heart Disease																
Cancer (include type)																
Mental Illness																
Depression																

Name: _____ Birthdate: _____ Today's Date:_____

SOCIAL MEDICAL HISTORY

Primarily lives with: ❑ Both Parents ❑ Mom ❑ Dad ❑ Grandparent ❑ Other (specify):
Parent's Relationship : ❑ Married ❑ Single ❑ Separated ❑ Divorced
Mother's Name: Father's Name:
Language spoken at home:
Does your child cooperate with family/friends? ❑ Y ❑ N
Does your child cooperate with teachers? ❑ Y ❑ N
Does your child have enough friends? ❑ Y ❑ N
Does anyone in the home use tobacco? ❑ Y ❑ N *Smoke? ❑Y ❑N Chew? ❑Y ❑N*
Does anyone smoke inside the home? ❑ Y ❑ N
Does anyone in the home use alcohol? ❑ Y ❑ N
Hand dominance: ❑ Right ❑ Left
Does your child wear a helmet when riding a bike? ❑ Y ❑ N
Does your child sit in a car seat? ❑ Y ❑ N *If Yes, What Type?*
Are there animals in the home? ❑ Y ❑ N *If yes, what type?*
Does anyone in the home own guns? ❑ Y ❑ N
In school, my child performs: ❑ Above Grade Level ❑ At Grade Level ❑ Below Grade Level
Does your child like school? ❑ Y ❑ N
Does your child have a learning disability? ❑ Y ❑ N
Does your child have special needs? ❑ Y ❑ N
Does your child sleep through the night? ❑ Y ❑ N
Does your child get a minimum of 8.5 hours of sleep? ❑ Y ❑ N
Does your child have nightmares or sleep problems? ❑ Y ❑ N
My child exercises / plays sports _____ hours per day.
My child watches TV / plays video or computer games _____ hours per day
Does anyone in the home use recreational drugs? ❑ Y ❑ N
Does anyone in the home use pain pills / opiates? ❑ Y ❑ N
Do you have religious affiliation? ❑ Y ❑ N *If yes, what religion?*

BIRTH HISTORY

Maternal Age: _____ Marital Status: Single Married Divorced Widowed
Do mother and father live together? Y N

Number of pregnancies: _____ Number of children delivered: _____

Number of living children: _____

Type of delivery: _____ Gestational age: _____

Birth weight: _____ Length at birth: _____

Apgar score: 1 min: _____ 5 min: _____ 10 min: _____

Hep B given at hospital? Y N Hearing test at hospital? Pass Fail

Parent / Guardian Signature: _____ Date:_____

Rocky Mountain Primary Care **Patient Portal**

Patient Name:_____Birth Date:_____

As a patient of Rocky Mountain Primary Care, you have access to secure **e-mail** directly with your provider and care team through the "Patient Portal." Here is a list of how you can use email to communicate with us:

- Request a routine appointment
- Ask your provider a non-urgent question
- Request copies of lab tests, immunization records, medication lists, and other test results (including X-Rays, CAT Scans, etc.)
- Request prescription refills
- ***We promise not to send you any "Junk" email!***

Please let us know if you are interested in using secure email through our Patient Portal. We will get you enrolled in the Patient Portal at your first visit.

❑ Yes, please sign me up for RMPC's Patient Portal. My email address is:

_____

❑ No, I do not wish to use email at this time.

Patient's Signature:_____

Date:_____

Rocky Mountain Primary Care **Patient's Authorized Contacts**

Patient's Name (please print) _____ Today's Date _____

Patient's Birthdate _____

Who Can RMPC Contact Regarding Your Care and Billing?

Contact persons with whom we may discuss your care, give test results and account and billing information:

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

Name _____Relationship _____ Phone #_____

Name _____Relationship _____ Phone #_____

May we leave confidential information on voicemail or answering machines listed below?

Home Phone_____ ❑ Yes ❑ No

Work Phone _____ ❑ Yes ❑ No

Cell Phone _____ ❑ Yes ❑ No

Patient Signature: _____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

_____ ____/____/____

Print Name Date of Birth

_____ ____/____/____

Patient (or Patient Representative*) Signature Today's Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

Notice of Privacy Practices for Protected Health Information (PHI)

Rocky Mountain Primary Care

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: June 1, 2015

The Practice of Rocky Mountain Primary Care is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student

training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

CORHIO Health Information Exchange

Rocky Mountain Primary Care endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the <CORHIO> HIE, or cancel an opt-out choice, at any time. Opt-Out forms are available at all our locations, or may be obtained by calling your primary care provider.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a

suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at (303) 205-0113, or in writing to us at:

Millard McQuaid
Rocky Mountain Primary Care
7625 W. 92nd Ave.
Westminster, CO 80021

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Rocky Mountain Primary Care **Medical Records Release**

PLEASE COMPLETE THIS FORM IF:
- ❑ We do not have records from your previous provider(s)
- ❑ You wish to have RMPC release your records to someone else

Authorization for Release of Personal Health Information (PHI)

Must Be Completed For All Authorizations:

I hereby authorize the use and disclosure of my personal health information as described below. I understand that this authorization is voluntary, and will in no way affect treatment, payment, enrollment or benefit eligibility. I further understand that I may inspect and copy any information disclosed pursuant to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____ SSN: _____

Person/organization providing the information:	**Person/organization receiving the information:**
_____	_____
_____	_____
_____	_____
_____	_____

The purpose for this authorized release of information is:_____

_____

❑ At the request of the individual

I authorize the health care provider to release the information specified below to the organization, agency or individual named on this request. I specifically authorize the release of information regarding the following condition(s). If these are not marked they cannot be released.

❑ Drug Abuse ❑ Substance Abuse ❑ Psychological or Psychiatric conditions ❑ AIDS/HIV

Please release the following records:

❑ All records generated in your office

❑ Other: _____

(Specific dates of treatment or specific description or information requested)

Are you leaving our practice? ❑ Yes ❑ No

If yes, please explain: _____

Must be Completed For All Authorizations:

1. I understand that this authorization will expire 90 days from the date of signature.
2. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations, and that the information may be re-disclosed by the parties listed, and no longer protected.
3. I understand that Federal and State Regulations allow for a reasonable fee to be charged for the duplication of Protected Health Information, and that I may be charged a fee to copy and mail the records I am requesting.

_____ _____ _____

Signature of Patient or Patient's Representative **Date** **Printed Name of Patient or Patient's Representative**

Revocation of Authorization:

I understand that authorization is voluntary and may be revoked at any time by signing below and returning to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby revoke this authorization, effective____/____/____

_____ _____ _____

Patient Signature (Representative) **Date** **Printed Name of Patient (Representative)**

What is the difference between an Annual Physical and an Office Visit?

An Annual Physical, Preventive, Or Wellness Visit

Is a visit focused on preventive care and immunizations.

Physical Exams may include:
- Pediatric – Development & Growth
- Female – Pap smears & Breast Exams
- Male – Prostate & Testicular Screenings
- Skin check

Healthy Lifestyles discussion
Immunizations
Lab testing as appropriate
Coordination of care/referrals for additional screenings:
- Mammograms
- Colonoscopies
- Eye Exams
- Other

Wellness visits are usually copay exempt.
If new or chronic conditions are addressed an office visit will also be performed and billed.

An Office Visit, Sick Visit Or Medication Check

Is an appointment where we discuss and evaluate new or existing medical conditions.

Office visit/Follow up appointment

- Evaluate & treat symptoms and concerns
- Address chronic problems
- Adjust medications & process refills
- Laboratory testing if necessary
- Process referrals if necessary

Copays, Deductibles and Co-Insurance may apply.

ROCKY MOUNTAIN
PRIMARY CARE

How did you hear about us?

Internet

- ❑ RMPC.info
- ❑ Insurance Plan's Website
- ❑ Search engine results (Google, Yahoo, Bing, etc.)
- ❑ Physician search website (HealthGrades, RateMDs, WebMD, etc.)

Word of Mouth

- ❑ Friend or Relative: _____
- ❑ Health Care Provider: _____

Other

- ❑ Driving by
- ❑ Yellow Pages
- ❑ Magazine/Newspaper