RIVERVIEW HEALTH PHYSICIANS

PATIENT INFORMATION

PATIENT NAME: _____ **SEX:** _____

DOB: _____ **SOCIAL SECURITY #:** _____ **PRIMARY CARE PHYSICIAN:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: ( ) _____ Circle One: Primary Secondary Tertiary **CELL:** ( ) _____ Circle One: Primary Secondary Tertiary **WORK:** ( ) _____ Circle One: Primary Secondary Tertiary

MARITAL STATUS: Married - Single - Widowed - Divorced - Minor **SPOUSE NAME & PHONE NUMBER:** _____

PREFERRED METHOD OF CONTACT: (Circle One) Phone - Postal Mail **PREFERRED LANGUAGE:** _____

RACE: (Circle One) Caucasian African American Hispanic Asian American Indian Other

ETHNICITY: (Circle One) Hispanic Non-Hispanic **E-MAIL:** _____

PARENT/GUARDIAN/FAMILY INFORMATION (Complete for minor patients only)

MOTHER'S NAME: _____

HOME PHONE: ( ) _____ Circle One: Primary Secondary Tertiary **CELL:** ( ) _____ Circle One: Primary Secondary Tertiary **WORK:** ( ) _____ Circle One: Primary Secondary Tertiary

FATHER'S NAME: _____

HOME PHONE: ( ) _____ Circle One: Primary Secondary Tertiary **CELL:** ( ) _____ Circle One: Primary Secondary Tertiary **WORK:** ( ) _____ Circle One: Primary Secondary Tertiary

PATIENT'S PRIMARY RESIDENCE: (Circle One) Mother Father Both Other: _____

SIBLINGS:

NAME: _____ **AGE:** _____ **SEX:** _____
NAME: _____ **AGE:** _____ **SEX:** _____
NAME: _____ **AGE:** _____ **SEX:** _____

UNINSURED

I do not have insurance and understand that I am financially responsible for the charges incurred.

Patient/Guardian Signature: _____

PRIMARY INSURANCE

Primary Insurance Company Name: _____

Policy Holder Name: _____ DOB: __/__/__

Social Security Number: _____ Relationship To Patient: _____

Employer Name: _____

SECONDARY INSURANCE (If Applicable)

Secondary Insurance Company Name: _____

Policy Holder Name: _____ DOB: __/__/__

Social Security Number: _____ Relationship To Patient: _____

Employer Name: _____

WORKER'S COMPENSATION INSURANCE (If Applicable)

If your visit is related to a work injury please notify the receptionist and provide your employer information.

SIGNATURE OF INDIVIDUAL COMPLETING FORM

Signature: _____ Date: _____

Patient Name:_____ **Riverview Health Physicians**
DOB: _____

GENERAL CONSENT TO MEDICAL TREATMENT

I request and authorize Riverview Health, their physicians, their associates and assistants (hereinafter "Physician(s)") who may attend to me and/or my dependent(s) during any visit, to perform routine medical tests and procedures and to provide drugs, medical care and other services as prescribed for me and/or my dependent(s) health and well-being. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me by Riverview Health or Physicians, nor have I relied upon any such representations, warranties, or guarantees.

_____ Initials and Date

MISSED APPOINTMENTS

I hereby agree to be responsible for Riverview Health's charge of $25.00 which may be assessed for appointments missed or cancelled with less than 24 hours notice. I understand these charges will not be submitted to my insurance.

_____ Initials and Date

RESPONSIBLE PARTY INFORMATION (Person signing form to accept financial responsibility)

RESPONSIBLE PARTY NAME: _____

DOB: _____ **SOCIAL SECURITY #:** _____ **PREFERRED LANGUAGE:** _____

ADDRESS: (If different from patient) _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PRIMARY PHONE: (____) _____ **SECONDARY PHONE:** (____) _____
Circle One: Home - Cell - Work **Circle One: Home - Cell - Work**

FINANCIAL AGREEMENT/CONSENT TO FILE INSURANCE

I hereby agree to be responsible for Riverview Health's charges for all services rendered. I shall also be responsible for any legal and/or attorney fees required to collect for these services, to which interest may be added at the current legal rate. I hereby assign directly to Riverview Health and Physicians payment of my health insurance benefits applicable to these services and authorize the collection of such funds on my behalf. Such payments shall not exceed my balance owed to Riverview Health. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment to insurance benefits. I also certify that any information which I have given in applying for coverage under the Social Security Act, or any insurance or other information, which I have provided, is true and correct. If I provide Riverview Health or its agents with my cell phone number, I authorize Riverview Health or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any e-mail I provide is my personal e-mail and I authorize Riverview Health or its agents to contact me via that e-mail address.

SIGNATURE OF RESPONSIBLE PARTY (18 years or older)

SIGNATURE: _____ **DATE:** _____ **STAFF INITIALS:** _____

Patient Name:_____ **Riverview Health Physicians**
DOB: _____

COMMUNICATION OF PRIVATE HEALTH INFORMATION AUTHORIZATION

Please √ and fill out all that are acceptable forms of communication to provide quality patient care.

☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my home voicemail or answering machine.

☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my cell phone voicemail.

☐ I authorize the staff of Riverview Health Physicians to leave a message regarding my Private Health Information on my work voicemail or answering machine.

☐ I authorize the staff of Riverview Health Physicians to mail written communication to my home address.

☐ I authorize the staff of Riverview Health Physicians to speak with the following individuals to discuss Medical and/or Financial information.

Medical:

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

Financial:

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

Emergency Contact: (Please list one individual not living at the same address)

Name	Phone Number	Relationship to Patient
Name	Phone Number	Relationship to Patient

All information signed and authorized by me on this form shall remain in effect until my written revocation.

_____ Initial/Date

HIPAA PRIVACY NOTICE ACKNOWLEDGMENT

By initialing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Riverview Health and may obtain a written copy upon request or via the website at www.riverview.org.

_____ Initial/Date

Patient or Legal Guardian's signature if patient is a minor	**Date**

STAFF USE ONLY

Riverview Health Physicians personnel witnessing form completion._____

Date: _____