STAFF USE:
Initial each step:
RXNT______
Scan _____
Med _____

River Bend
Family Medicine

Personal Statistics

Last Name ________________________ First Name __________________ Middle Initial _____

Preferred Name ______________ M F Social Security Number _____-_____-________

Birth Date: ______/______/_______ Marital Status: Married/Single/Widowed/Divorced

Ethnicity: ________________ Race: ____

Address ___________________________________

____

How to you prefer to be reminded of your upcoming appointments? Circle one
Email Phone Text

City/Town __________________ State _____ Zip _____________

Preferred Phone ( )______-_______________ Secondary Phone ( )______-________________

Email (please print carefully)__________________________________

Employment Information

Employer Name ________________________ Employer Phone ( ) ______-_______________

City ____ State _______ May we contact you at work? Y N

Emergency Contact Information

Contact Name: ___________________________ Relationship: ____________________________

Address ________________________________ City ______________________ State _______

Phone: ( )_____-________________

Other

How did you find us? ___________________ Previous primary care provider? ___________

Payment Information

Guarantor Information: MUST BE COMPLETED FOR PATIENTS UNDER 18

Name of person responsible for payment: ________________________________

Relationship to patient: _______________________

Address: ____________________________________

City: _____________________ State ____ Zip _____________ Phone: ( ) _______-______________

Insurance Information

Are you the primary insured? Y N(If yes, skip this section and continue to the Insurance section)

Primary Insured Name ___________________________
Address ____________________________
City ______________________ State _____ Zip _____
Phone ( )_____-__________
Date of birth ____/______/_________ SSN ______-___-______

Insurance Company ________________________

Subscriber ID ____________________ Group # ______________ Plan name _______________

Co-pay _________

Medicare #: Please provide this even if you have a Medicare Advantage plan. ______________

I authorize River Bend Family Medicine to bill my insurance company.

Sign, please____

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River Bend Family Medicine.
New Patient Medical History

Name____

First Name Middle Name Last Name Date of Birth

MEDICAL HISTORY

Do you currently have....

- ❒ Diabetes Type 2
- ❒ High Blood Pressure
- ❒ High cholesterol
- ❒ Heart disease
- ❒ COPD or emphysema
- ❒ Tobacco Use
- ❒ Obesity or overweight
- ❒ Depression
- ❒ Anxiety
- ❒ GERD
- ❒ Hypothyroid
- ❒ Congestive heart failure
- ❒ Atrial fibrillation
- ❒ Colon polyps
- ❒ History of cancer (If yes, what type?)
- ❒ Arthritis
- ❒ Headaches
- ❒ Liver disease
- ❒ Kidney disease
- ❒ Asthma
- ❒ Environmental Allergies
- ❒ History of stroke or TIA

List below other health issues you have been treated for in the past:

DRUG ALLERGIES:

Name of Medicine	What was the reaction (rash, short of breath, etc...)
1	
2	
3	
4	

SOCIAL HISTORY

Y N Alcohol Use; If Yes, how much per day?________________________

Y N Drug use _____________ ______________________________________

Y N Have you ever used tobacco? If Yes, how much and when

(Describe)_________________________________

FAMILY HISTORY: Please list if a relative has had one of the following conditions:

Y N Colon Cancer	Y N Heart Disease
Y N Prostate Cancer	Y N Stroke
Y N Breast Cancer	Y N Diabetes
Y N Ovarian Cancer	Y N Depression
	Y N Osteoporosis

Please list below any other important conditions that have affected family members:

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IMMUNIZATION & HEALTH MAINTENANCE HISTORY

Date of last Tetanus shot__________ Date of Pneumonia Vaccine__________

Most recent colonoscopy__________

Women: Date of Last Pap Test ________

Most recent mammogram___________

CURRENT MEDICATIONS:

Name of Medicine, Dose	How is the medicine taken (once per day, twice per day, etc...)
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Nutritional supplements currently taking?

1	3
2	4

PAST SURGERIES AND HOSPITALIZATIONS:

Type of Surgery/Reason for Hospitalization	Year
1	
2	
3	
4	
5	
6	
7	
8	

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Pain and Controlled Substance Policy

- Our providers provide **end-of-life and cancer-related pain management**, and will try all appropriate measures to achieve patient comfort in these cases.
- **Patients New to Our Practice:** our physicians will not consider prescription of a controlled substance without first viewing past medical records that detail a patient's diagnosis, previous evaluation, and treatment history. All patients are objectively evaluated, and we attempt to create a care plan that does not involve controlled substances; if controlled substances are required (and the patient is not involved in Hospice or cancer care), the patient will most likely be referred to a pain management practice or other appropriate specialist.
- **Established patients** with whom the clinical team has an established bond of trust, may, at the sole discretion of the physician, be treated with narcotics and other controlled substances, both acutely and on a chronic basis. We reserve the right to request random testing at any time.
- **Controlled substances (narcotics, ADHD stimulants, benzodiazepines) will only be refilled during business hours, Monday through Friday. Controlled substances will not be refilled after hours on weekdays or on weekends.**

I understand and accept RBFM's Controlled Substance Policy ______________________________

signature

Antibiotic Use and Prescribing

Resistance to antibiotics is a serious issue. We try to use antibiotics only when appropriate. Patients with a problem that may require an antibiotic should be seen and evaluated by a physician, who will determine the appropriate care. Patients who call after having been seen by the physician, who have failed to improve, or have developed new symptoms, may receive an antibiotic without being seen again, at the discretion of the physician. Exceptions to this policy may be made at the sole discretion of the physician.

I understand and accept RBFM's Antibiotic Use Policy ____________________________________

signature

Missed Appointment Policy

We make every attempt to schedule appointments at the convenience of our patients, including providing same-day appointments to sick patients. **To better serve all of our patients, we require a 24 hour notification should you need to cancel or reschedule your appointment.**

Should you miss, or reschedule your appointment with less than a 24 hour notice, you will be charged $25.00, and payment will be due at the time of your next appointment. Your insurance company does not cover fees for missed appointments. If you are a Medicaid patient, we are not allowed to charge for missed appointments, so we may decide to revoke your privilege of making appointments. Upon missing three or cancelling inappropriately, 3 or more appointments, we reserve the right to discharge you from our practice.

I understand and accept RBFM's Appointment Policy _____________________________________

signature

Patient's Rights

- You have a right to respectful and compassionate care.
- You have a right to participate in, and receive information about, your plan of care.
- You will not be denied care due to race, creed, color, national origin, sex, age, sexual orientation, disability, or source of payment.
- You have a right to refuse treatment, and to be informed of the possible consequences of refusal of treatment.
- You are entitled to be free from all forms of abuse and harassment.
- You have the right to have an appropriate representative make informed decisions about your care.
- You have the right to determine advanced directives, and to have them followed.
- You have a right to privacy and a safe environment.
- You have the right to a prompt response to any reasonable request.
- You have the right to see your medical records.
- You have a right to an explanation of all items relating to your bill.

Patient Responsibilities

- You are responsible to provide accurate and complete information regarding all medical issues and medication use.
- You are responsible for following your plan of care. If you refuse treatment, or do not follow your plan of care, then you must accept the consequences.
- It is your responsibility to notify a member of our staff if you have trouble understanding or following any aspect of your care.
- You are responsible to notify our staff of any new problems or changes in your condition.
- You are expected to act in a considerate and respectful manner during any interaction with our staff. We will discharge any patient behaving inappropriately with our staff.
- You are responsible to keep your scheduled appointments or to notify our office in advance if you cannot keep an appointment. (We charge $25 for “no shows”-see Appointment Policies).
- You are expected to pay your bills, or to make an arrangement with our office to meet your obligations (see Payment Policies).

I accept my responsibilities as a patient ___________________________________

signature

Release to Discuss Information with Designated Person

I hereby authorize River Bend Family Medicine to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to those terms.

____ ____________

Name Date

Authorization to Discuss Information with Designated Person

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patients' care. In this event with your signed authorization we would discuss such information to a person you designate. Please complete the section below:

I hereby authorize River Bend Family Medicine to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s)

Name of Designee: ____________________________

Phone Number: ___________________________

Relationship to Patient: ____________________________

Name of Designee: ____________________________

Phone Number: ___________________________

Relationship to Patient: ____________________________

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River Bend Family Medicine
Patient HIPAA Consent
for Use and Disclosure of Protected Health Information

I hereby give my consent for River Bend Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by River Bend Family Medicine, LLC. describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

River Bend Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to River Bend Family Medicine, 131 Pennsylvania Avenue, North, Hancock, MD 21750.

With this consent, River Bend Family Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, River Bend Family Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, River Bend Family Medicine may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that River Bend Family Medicine restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow River Bend Family Medicine to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, River Bend Family Medicine may decline to provide treatment to me.

____
Print Patient’s Name

______________________________ ____________________
Signature of Patient or Legal Guardian Date

____
Print Name of Legal Guardian, if applicable

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River Bend

Family Medicine

Payment Policy

1. **Insurance**: It's **your** responsibility to make sure River Bend Family Medicine is in network with your plan. If you aren't insured by a plan we do business with, payment in full is expected at each visit. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. Please be sure to respond to any requests for information from your insurer. If they think you have an additional health plan, they may not pay your claims.
2. **Payment on the Day of Service is expected!** Your co-pay, your balance, or if you are a cash patient – your payment is due on the day of service. We give cash patients the same discount insurers give their subscribers, but if we have to send you a bill because you didn't pay when you were here for your visit, ***we will not extend the discount. If you chronically don't pay your co-pay, we reserve the right to bill you $10 every time we have to send you a bill.*** If 3 statements are sent WITHOUT a payment plan arrangement, the balance will be sent to collections.
3. **Non-Covered services**. Please be aware that some of the services you receive may not be covered by your insurance. If services are not covered you are liable to cover the remaining balance.

   your plan. We will ask you to sign an Advanced Beneficiary Notice when we're not sure whether or not a visit will be paid.
4. **We can help!** If you need to pay your balance in installments, all we ask is that you authorize us to charge your credit card or checking account on file every month. We accept payment plans for as little as $15 a month regardless of your balance. We may **require** you to make installment payments with your credit card/bank account if you are making no effort to pay your balance. ***This is not available for self-pay patients or patients on the discount program!***
5. **We have an income-based discount program for those who have no insurance and are having trouble paying for healthcare.** You will need to provide us with proof of income. **Only patients with no insur-ance are eligible. Patients on the discount plan MUST PAY ON THE DAY OF SERVICE, or be charged the regular fee.**
6. Patients wanting to take advantage of telehealth visits **must** have a credit card or checking account on file (this doesn't apply to Medicare patients).
7. **Nonpayment**: We need to see a commitment from you to pay down your balance. (See #4). When you show no interest in trying to pay for your healthcare, we may decide to discharge you from the practice. Collections will be levied if no attempt is made to pay down the balance.

I have read and understand the payment policy and agree to abide by its guidelines:

____

Signature of Patient Or Responsible Party **Date**

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Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers using your phone, computer, or other device. Telehealth might be a telephone call only, or it could include video. It's up to our providers to decide whether your visit is appropriate for telehealth.

How do I use telehealth?

We can use one of several technologies to connect with you. Our staff will help you the first time you use it.

Why are we using telehealth?

In this age of COVID, we are only using telehealth for our sick patients whenever possible. This keeps our patients coming in for well visits, injuries, and non-contagious conditions from getting sick. It keeps our staff safe too!

You don't have to be sick to request telehealth. We understand people aren't too excited about going anywhere that might expose them.

Even in "normal" times, a telehealth visit might be more appropriate than an in-office visit.

Will my telehealth visit be private?

We never record your visit.

You should make sure you're in a place when using telehealth that will protect your privacy.

How much does a telehealth visit cost?

- It costs no more than a regular visit.
- We will expect your co-pay on the day of service or a payment play arranged.
    - We suggest that you to keep a credit card or your checking account information on file with us if you want to use telehealth.
    - Your telehealth privileges will be suspended if you don't pay your co-pay. If you don't have a card on file, we expect payment of your copay within 15 days, either by mail, or by calling the office with your credit card. If we have to send you a bill, we will charge you a $10 late fee.
- Do I have to sign this document?
- No. Only sign this document if you want to use telehealth.

Your name (please print) Date

Your signature Date

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River Bend
Family Medicine
131 N Pennsylvania Ave
Hancock MD 21750
www.riverbendmd.com

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME: ___________________________________DATE OF BIRTH___________________

ADDRESS: ____SS#:________________________

____

I hereby authorize: Name: ____

Address: ____

____

To release to: Name: ____

Address: ____

____

Description of specific information to be disclosed:

Office notes from __________to ___________

__Lab tests __X- rays __ultra sounds __CT scans __MRI __ immunization records

The purpose for the release of the above information is: ____Continued Care ___Legal reasons ___Insurance reason ___Other:

____

I understand that:

- I may revoke or terminate this authorization by contacting River Bend Family Medicine and completing a Revocation of Authorization form.
- I may inspect or copy the protected health information to be used or disclosed.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected under HIPPA.
- I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed and my treatment will not be affected by my refusal to sign this authorization.

Signature of Patient :_______________________ Date signed:________________