Office Use Only:
Initials each step:
Oxbow _____
Practice Mate _____
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 _____
_____
City/Town _____ State _____ Zip _____
Primary Phone ( )_____-_____ Secondary Phone ( )_____-_____
Email _____

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

Signature _____

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

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:

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	

Please review and sign each section below. You may request a copy of this document.

Pain and Controlled Substance Policy

- Our physicians 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.

_____ _____

Name Date

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.

_____ _____

Name Date

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 may decide to revoke your privilege of making appointments; instead, you may come to the office and wait until a provider can see you. Upon missing three or cancelling inappropriately 3 or more appointments, we reserve the right to discharge you from our practice.

_____ _____

Name Date

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.

_____ _____

Name Date

Patients' Responsibilities

- You are responsible to provide accurate 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.
- 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”).
- You are expected to pay your bills, or to make an arrangement with our office to meet your obligations.

_____ _____

Name Date

Use and Disclosure of Protected Health Information

- The educational pamphlet entitled “Notice of Privacy Practices” provides information about how River Bend Family Medicine may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Our Notice of Privacy Practices states that we reserve the right to change the terms described.
- You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our Notice of Privacy Practices.

_____ _____

Name Date

Release of 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: _____

Online Appointment Scheduling

Would you like to be able to schedule appointments online? Please print clearly your email address and we'll send you a code that gives you access to our scheduling portal Patient Ally. (note: We also have a clinical portal that gives you access to your medical records – ask one of our staff about that portal).

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.
2. **Payment on the Date 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, 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.
3. **Non-covered services**. Please be aware that some of the services you receive may not be covered by 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.
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 insurance are eligible.**
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.

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

_____ _____

Signature of Patient Or Responsible Party **Date**

….a new way to practice old-fashioned care

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers using your phone, computer, or other device.

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.

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.

Almost every single insurer is waiving co-pays for any COVID-related

If your visit is not COVID related we will expect your co-pay on the day of service

We require you to keep a credit card or your checking account information on file if you want to use telehealth (unless you are a Medicare patient. Medicare Advantage patients must keep a card or account on file).

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

OPTIONAL!

River Bend Family Medicine

River Bend Family Medicine can keep your credit card information securely, and make your payments for you. You won't need to wait at our check-in while we process your co-pay, nor will you need to bother with billing statements and checks. Payments to your card are processed only after the claim has been filed and processed by your insurer.

We may REQUIRE this information if you have an account balance that is being paid in installments.

We can email your receipt to you along with the billing statement we've paid for you, or keep them at the office until you pick them up.

I authorize River Bend Family Medicine to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐Amex ☐Visa ☐Mastercard ☐Discover

Maximum amount to be billed $_____ Date of month you'd prefer to be billed? ___ If making monthly payments on a balance, how much per month do you want to pay until your balance is paid off? $_____

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State**_____ **Zip** _____

Email address _____

I (we), the undersigned, authorize and request [practice name] to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by River Bend Family Medicine

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to River Bend Family Medicine in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____