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
- ❐ 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:

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 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.
- 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. Should this happen, you will receive a revised copy either by mail, or in person.
- 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: ___________________________

Payment Policy

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. All patients must provide a current valid insurance card to provide proof of insurance. 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. **Co-payments and deductibles.** You are obligated to pay your co-pay at the time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. We reserve the right to bill you $10 when you don’t pay your co-pay on the day of your appointment. You may opt to be automatically billed for your co-pays and deductibles.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. We will ask you to sign an **Advanced Beneficiary Notice** when we’re not sure whether or not a visit will be paid.

4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

5. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. We may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

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

____________________________________ _____________________

Signature of patient or responsible party **Date**

3/17/2016

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: ____

Date: _____ / _____ / _____

3/17/16