Riverwood Family Medicine PC

Patient Demographics

 Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP: FREDRICKSON CLARK

PATIENT’S FIRST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIDDLE INITIAL \_\_\_\_DOB\_\_\_\_\_\_\_\_\_

PREVIOUS NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX M F

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: MARRIED SINGLE

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIVORCED WIDOWED

STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARTNER LEGALLY SEPARATED

HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 EMERGENCY CONTACT

 NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Statements will be addressed to the responsible party) ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT

PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK TO LEAVE VOICE MAILS:

◌ HOME # ◌ CELL #

RACE: ASIAN NATIVE HAWAIIAN/OTHER PACIFIC BLACK OR AFRICAN AMERICAN

 WHITE HISPANIC OTHER

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO
LANGUAGE: ENGLISH SPANISH INDIAN RUSSIAN OTHER

PHARMACY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LOCATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREFERRED LAB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LOCATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE GIVE THE RECEPTIONIST YOUR PHOTO ID AND INSURANCE CARD

Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RIVERWOOD FAMILY MEDICINE**

**NEW PATIENT-MEDICAL HISTORY FORM**

***Please complete this form and bring it to your appointment. You may also mail it back to the office prior to your appointment date.***

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full-legal name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies or drug reactions (list drug and reaction):

Please list the conditions you are currently being treated for:

Please list any other doctors who are also currently treating you:

**Past medical history** (Please list all hospitalizations, major illnesses and surgeries):

|  |  |
| --- | --- |
| *Event* | *Date of Occurrence* |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Who lives in your home with you? (Spouse, children, in-laws, significant others, etc.)

Your occupation:

Do you get regular exercise? (Describe)

Do you wear seatbelts (Circle) Always Usually Occasionally Never

Smoking history: (please check)

\_\_\_\_ never smoked \_\_\_\_previous smoker x \_\_\_\_years; quit \_\_\_\_\_ (when?)

\_\_\_\_current smoker x \_\_\_\_\_\_years; \_\_\_\_\_ packs per day

Do you use other forms of tobacco such as chewing tobacco, pipe, cigars, e-cigs, vape?

If yes, how often?

Alcohol Screen:

Do you drink beverages that contain alcohol?

How often do you have alcoholic beverages? 1/month 1/week

More than 1/week More than 1/month

Have you ever had a drinking problem?

How many cups of coffee or caffeinated drinks do you drink daily?

Do you use marijuana, cocaine, any street drugs or prescription drugs that were not prescribed for you?

**Do you have any specific concerns for your first visit? (Describe)**

**Family History:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | *Age, if living* | *Age at death* | *Health problems or cause of death* |
| Mother |  |  |  |
| Father |  |  |  |
| Siblings |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Children |  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Medications:** (Please list all the medication you are taking, including over-the-counter medications, vitamins, herbs and other treatments.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Name of medication* | *Prescribed by* | *Dosage* | *When is the medication taken* | *Purpose* | *Will you be in need of refills at your visit?* |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Vaccinations:**

|  |  |
| --- | --- |
| *Vaccine* | *Date of last one* |
| Tetanus (Td, TdaP, Dtap, Tetanus Toxoid) |  |
| Influenza |  |
| Pneumonia |  |
| Hepatitis B |  |
| Shingles (Zostavax) |  |
| Others (please list) |  |
|  |  |
|  |  |
|  |  |
|  |  |

**History of Tests/Exams:**

|  |  |
| --- | --- |
| *Exam* | *Date last completed* |
| Colonoscopy |  |
| Bone Density |  |
| Mammogram |  |
| Pap Smear |  |
| PSA  |  |
| Eye exam |  |
| Others (please List) |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Do you currently have any of the following?**

**(If yes, please notify the provider at the time of your visit)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | *Yes* | *No* |  |  | *Yes* | *No* |  |  | *Yes* | *No* |
| Fatigue |  |  |  | Weakness |  |  |  | Swelling in arms or legs |  |  |
| Fever or chills |  |  |  | Cough |  |  |  | Dizziness |  |  |
| Recent weight change |  |  |  | Wheezing |  |  |  | Fainting |  |  |
| Headache |  |  |  | Decreased appetite |  |  |  | Memory problems |  |  |
| Vision changes |  |  |  | Difficulty swallowing |  |  |  | Numbness |  |  |
| Eye itching |  |  |  | Heartburn |  |  |  | Anxiety |  |  |
| Eye pain |  |  |  | Vomiting |  |  |  | Depression |  |  |
| Ringing in ears |  |  |  | Nausea |  |  |  | Trouble sleeping |  |  |
| Runny nose |  |  |  | Abdominal pain |  |  |  | Hallucinations |  |  |
| Nose bleeds |  |  |  | Black tarry stools |  |  |  | Dry skin |  |  |
| Nasal congestion |  |  |  | Rectal bleeding |  |  |  | Itching |  |  |
| Snoring |  |  |  | Diarrhea |  |  |  | Lump or spot on skin |  |  |
| Hoarseness |  |  |  | Constipation |  |  |  | Rash |  |  |
| Sore throat |  |  |  | Blood in urine |  |  |  | Stress |  |  |
| Mouth sores |  |  |  | Urinating too often |  |  |  | Other (please list): |
| Breast lump or pain |  |  |  | Pain with urination |  |  |  |
| Chest pain |  |  |  | Excessive thirst |  |  |  |
| Irregular heart beat |  |  |  | Easy bruising |  |  |  |
| Pounding heart beat |  |  |  | Muscle aches |  |  |  |
| Shortness of breath |  |  |  | Joint pain or stiffness |  |  |  |

***Riv*erwood Family Medicine Practice Guidelines and Financial Policies**

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Assignment of Benefits***

I hereby authorize benefits to be paid directly to Riverwood Family Medicine. I authorize the release of pertinent medical information and records to my insurance company or referral physicians. I also authorize the referral physician to release records to my primary care physician. I understand that I will be responsible for payment of all copays, deductibles, and non-covered charges that my insurance doesn’t pay. Any procedures or visits that my insurance, including BCBS and Medicare, deem not payable because they are preventative, routine, or considered medically unnecessary, will be my responsibility to pay.

Initials:

***Electronic Communication Authorization***

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging, or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address that I have provided.

Initials: 

***Physical Exam Billing and coding***

Because insurance billing issues can be confusing, we want to inform you of our responsibility in billing you and your health insurance company for Physical Exams.

If you are here for a preventative exam (sometimes called an annual physical, annual wellness visit or well visit), we must clearly indicate that when we bill your insurance company. The exam code we use indicates that the visit is for preventative health care, not for a new or recurring medical problem.

If you receive care for a new or recurring medical problem during a preventive exam, the diagnosis codes we report to your insurance company must reflect that medical problem. We must also document care for this problem in your medical chart. Please note that receiving care for a medical problem during a wellness visit may result in different out-of-pocket costs for you than you may expect for your preventative exam.

Our billing department bills exactly what your doctor has reported for the visit. The billing department cannot change the codes before reporting them to your insurance company. They must reflect the services you received during your visit.

Initials: 

***Acknowledgment of Notice of Privacy Practices***

I have received (or was offered) a copy of Riverwood Family Medicine’s Notice of Privacy Practices.

Initials: 

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Practice Guidelines and Policies***

* ***Emergencies:*** Our providers will make every effort to receive your urgent calls and respond promptly. If you perceive your symptoms to be life-threatening you should call 911.
* ***Prescription refills:*** It is our policy that you be responsible to know when your medications must be refilled at least 1 week before you will run out. Medications can be requested during regular office hours through our prescription refill line, at an office visit or via the patient portal. We cannot take weekend, walk-in or after-hours requests. Phone requests require a 24 hour processing time.
* ***Telephone encounters and sick patients:*** Our providers do not treat new patients or new illnesses over the telephone. You will be required to schedule an office visit for evaluation.
* ***Phone triage:*** The clinical staff is available for phone consultation during regular business hours. Please allow a reasonable amount of turn-around time on questions forwarded to the providers.
* ***Information:*** You agree to provide your legal name, current address and phone number, insurance information, social security number, and a picture ID at the time of registration or as requested by the practice at any time.
* ***Financial responsibility:*** You accept financial responsibility for all services rendered to you. If the patient is a minor or under guardianship, the parent or guardian accompanying the patient assumes the liability. A signature from the parent or guardian is required.
* ***Payment methods:*** We accept cash, check and Visa, MasterCard, Discover and American Express. Payment is expected in full at the time of service.
* ***Appointments:*** Our office will schedule appointments as a common courtesy for patients and in consideration of your time. Minors must be accompanied by a parent or guardian unless prior arrangements have been made. We require a 24 hr. notice of cancellation as a courtesy to other patients seeking services. A fee of $25 is charged for missed appointments ($50 for missed physicals, $10 for nurse visits). A pattern of missed appointments may result in discharge from the practice. If you arrive 10 minutes or more after your scheduled appointment time, you may be asked to reschedule your appointment.
* ***Medical records:*** The medical chart is the property of the practice. However, copies of your pertinent medical information are available upon request. There are fees associated for a copy of the record. A custodial record transfer fee is charged if you are transferring your care to another physician. The fee schedule is available upon request. There is no fee required for any records forwarded to offices on the basis of a referral. We currently utilize HealthPort (Ciox) as our records copying service
* ***Insurance, co-pays, deductibles:*** Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All copayments, deductibles, coinsurance or non-covered services are to be paid at the time of service. If requested, you will need to sign an advanced beneficiary notice or notice of non-covered services prior to certain services rendered. You accept responsibility for all such expenses if the services are not covered by your insurance.
* ***Payment without insurance:*** We require payment in full at the time of service unless an alternative arrangement has been discussed and approved by the office manager or physician.
* ***Usual and customary:*** Some insurance plans may indicate that our fees are above “usual and customary.” As a result your plan may reduce our fee to an “allowed amount” before calculating payment. Unless we have specifically contracted with your carrier, it is expected that you will be liable for any uncovered fees.
* ***Accident and workers’ compensation:*** You are required to obtain proper authorization with your employer prior to being seen and provide the practice with all of the correct billing information. This also applies to motor vehicle accident claims.
* ***Statement policy:*** Our office sends out statements each month. Payments are due upon receipt. You understand that if we participate with your insurance company, the sending of a statement may be delayed until the insurance responds to the claim for services.

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* ***Test results:*** Routine labs and radiological results are relayed via phone, mail or via the patient portal within 14 days of received reports, unless you have an upcoming appointment within a month. Urgent and emergent results are called as soon as they are available.
* ***Collection and bank fees:*** Accounts more than 90 days old are subject to transfer to an outside collection agency. In addition, banks charge for checks that do not clear. You will be liable for all such fees with a minimum charge of $30.00.
* ***Patient discharge:*** This practice reserves the right to discharge a patient for any reason. Please note that discharges may occur for failure to meet your financial obligations, repeated missed appointments, failure to comply with treatment plans or behavioral misconduct.
* ***Insurance claims:*** If applicable, our office will submit insurance claims. You agree to allow our practice to “accept assignment” of benefits and receive payment directly from your insurance company. In the event your insurer sends payment for a claim from our office directly to you, you agree to endorse the payment to our practice in fulfillment of any amounts due.
* ***Office hours:*** Our office is open for appointments Monday through Friday, 8:30am-4:30pm. The office is closed for lunch from 11:45am-1:15pm.
* ***Requests for letters or forms:*** We reserve the right to submit a reasonable charge to patients for the completion of forms or dictated letters on request. Turn-around time for completion is up to 10 business days.
* ***Mailed prescriptions:*** Should you require any written prescription to be mailed to your home and/or pharmacy, you will need to provide the office with self-addressed, stamped envelopes.
* ***Orders:*** It is your responsibility to know which lab, radiology and physical therapy facilities you may use with your insurance as well as knowledge of your insurance benefits such as immunizations, injection coverage, vision exams, and chiropractic care. You must inform the staff prior to ordering if you require a specific facility or provider.
* ***HIPAA:*** Our office is committed to compliance with HIPAA guidelines.
* ***PCMH:*** Our office is committed to the Patient Centered Medical Home concept.
* ***Patient Portal:*** Our office offers easy and private access to your medical information and on line communication via the patient portal. You will be asked to supply an email address in order for you to set up an account.
* ***Website:*** www.riverwoodfamilymedicine.com

Initials: 

***Office Financial Policy***

* Our goal is to provide and maintain a good physician-patient relationship. We are committed to providing you with the best possible care. We need your understanding of our financial and payment policies.
* Payment is always required at the time of service. We accept cash, check or credit.
* We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the date services are rendered. Therefore, it is necessary for you to know your benefits and coverage that your insurance provides for you.

Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

