River Valley **Healthcare** Associates

Today's Date:_____

# Patient Information

Patient Number:

| First Name | Middle Name | Last Name |
|---|---|---|
| | | |

| Sex | Marital Status | Date of Birth | Social Security Number |
|---|---|---|---|
| | | | |

| Patient's Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Cell Phone | Work Number | Ok to call at work? |
|---|---|---|---|
| | | | |

| Ethnicity | Race | Preferred Language |
|---|---|---|
| | | |

| Occupation | Employer | How Did You Hear About Us? |
|---|---|---|
| | | |

| Preferred Pharmacy | Pharmacy Cross Streets | Pharmacy Phone Number |
|---|---|---|
| | | |

## Parent/Guardian/Spouse/Domestic Partner

| First Name | Middle Name | Last Name |
|---|---|---|
| | | |

| Sex | Marital Status | Date of Birth | Social Security Number |
|---|---|---|---|
| | | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Cell Phone | Work Number | Ok to call at work? |
|---|---|---|---|
| | | | |

## Primary Medical Insurance/Work Comp Insurance/Auto Insurance

| Insurance Company Name | ID # | Group # |
|---|---|---|
| | | |

| Street Address | City, State, Zip | Phone # |
|---|---|---|
| | | |

| Name of Subscriber,(MUST HAVE name, SSN, DOB to bill) | Social Security # | Subscriber's Date of Birth |
|---|---|---|
| | | |

**Work Comp and Auto Insurance Only** **Date of Accident:** **Claim's Adjuster Name:**

## Secondary Medical Insurance

| Secondary Insurance Name | ID# | Group # |
|---|---|---|
| | | |

| Street Address | City, State, Zip | Phone # |
|---|---|---|
| | | |

| Name of Policy Holder | Social Security # | Date of Birth |
|---|---|---|
| | | |

## Emergency Contact Information

| Name | Relationship | Phone # |
|---|---|---|
| | | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

## ADVANCED DIRECTIVES

Check the boxes that pertain to you. We require copies of the items pertaining to you for our records.

- ☐ None
- ☐ Do not resuscitate (DNR)
- ☐ Do not intubate only (DNI)
- ☐ Durable Power of Attorney
- ☐ Living Will
- ☐ Health care proxy

## AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement , I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The reponsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further understand that if I do not show for an appointment or do not give 24 hours notice to River Valley Healthcare Associates, PC when canceling an appointment I may be responsible for the charges up to the potential cost of the visit.

X _____

RESPONSIBLE PARTY SIGNATURE PRINT NAME DATE

## RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, hereby authorize River Valley Healthcare Associates, PC, and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges. I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient. I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled. I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care. I, authorize and request that payment of any third party or insurance company benefits be made directly to River Valley Healthcare Associates, PC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X _____

RESPONSIBLE PARTY SIGNATURE PRINT NAME DATE

## CONSENT FOR TREATMENT

By signing below, I, the undersigned patient (or authorized representatve) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers.

X _____

RESPONSIBLE PARTY SIGNATURE PRINT NAME DATE

*Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.

*Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service-Please have this ready prior to your visit as well. as any current balance due. If copayor past due balance is not paid at the time of visit, patient may be required to reschedule the appointment.

*Patient is responsible for all labwork and must be prepared to tell the RVHA staff which lab their insurance requires them to use. If presenting new insurance on the day that labs are drawn, the patient should inform the patient person drawing their labs. RVHA will not be able to make changes to the lab company once the lab leaves our office for processing.

*I verify that all the information above is correct to the best of my knowledge at this time.

X _____

RESPONSIBLE PARTY SIGNATURE PRINT NAME DATE