

Facility: _____ Dept.: _____ PCP: _____ Account #: _____ Chart #: _____ Date: _____

PATIENT INFORMATION

Name: _____
Last First Middle Initial

Address: _____
Number Street Apt.

City State Zip

Home Telephone Number: _____

E-mail address: _____

Mobile Number: _____

Employer: _____

Retired: _____ **Disabled:** _____ **Unemployed:** _____ **Student:** _____

Emergency Contact Information:

Contact Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____

Contact Name: _____ Relationship: _____ Home Phone: _____ Work Phone: _____

Relationship of Patient to Guarantor: Self _____ Spouse _____ Child _____ Other (please Specify) _____

Birthdate: _____ / _____ / _____

Sex: Male _____ Female _____

Soc. Sec. # _____ / _____ / _____

Marital Status: Married _____ Single _____

Divorced _____ Legally Separated _____

Widowed _____ Domestic Partner _____

Work Telephone #: _____

GUARANTOR INFORMATION (Person Financially Responsible)

Guarantor Name: _____
Last First Middle Initial

Guarantor Address: _____
Number Street Apt.

City State Zip

Guarantor Telephone Number: _____

Guarantor Employer: _____

Retired: _____ **Disabled:** _____ **Unemployed:** _____

Birthdate: _____ / _____ / _____

Sex: Male _____ Female _____

Soc. Sec. # _____ / _____ / _____

Occupation: _____

Employer Telephone #: _____

FINANCIAL GUIDELINES FOR HEALTH CARE SERVICES

Please present your insurance card at every visit.

As a courtesy to you, we will bill your health insurance company directly in most cases.

You will be responsible for payment of any copayment or deductibles required by your insurance plan.

If your insurance company denies or delays payment, we will bill you directly.

Copayments are due and payable at the time of your visit.

We accept MasterCard, Visa and Discover Card.

If you pay by check and it is returned, it will be necessary to apply a \$25 fee to your account.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, (patient's name) acknowledge that I have received the Notice of Privacy Practices of Riverbend Medical Group, which describes Riverbend's polices and procedures regarding the use and disclosure of any of my Protected Health Information.

Signature (Patient, Parent, Guardian) _____ Date _____

Print Name _____

ASSIGNMENT OF BENEFITS

The Non-Medicare Patient: I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to *RiverBend Medical Group*.

The Medicare Patient: I request that payment of authorized Medicare/Medigap benefits be made on my behalf to *RiverBend Medical Group* for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services, its agents or my Medigap Insurer _____, any information needed to determine benefits or the benefits payable for related services.

I certify that the information given by me is correct. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I may be responsible for any amount not covered by insurance.

Signature: _____
patient parent or guardian

witness date