RIVERS EDGE FAMILY MEDICINE

Please arrive 15 mins early with the completed paperwork and your Insurance Card(s) and Photo ID

Patient Name: _____ Date of Birth: _____ Age: _____

Preferred Name: _____

Parent or Gurardian if patient is under 18 years old: _____

Social Security#: _____ Birth Gender: M / F **Marital Status:** Married Single Partner Divorced Widowed

Mailing Address: _____

City, State, Zip: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

May we leave a message at your home or cell number? Y / N

Email: _____ **Patient Portal Invite:** Y / N

Employer: _____ Occupation: _____

Who is your appointment with today? _____

Responsible Party Information (if different than above) _____

Relationship To Patient: _____ Date of Birth: _____

Social Security #: _____ **Gender:** M / F

Mailing Address: _____ City, State, Zip: _____

Employer: _____

Cell Phone: _____ Work Phone: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Can we share your healthcare information with your emergency contacts? Y/ N

Federal Health Regulations now require that we record the following data as part of every health record.

Race: _____ Language: _____ Ethnicity: _____

OR check this box to refuse to provide this information: [ ]

Preferred Pharmacy: _____ **Address & Zip Code:** _____

Phone number: _____

In order for us to bill your insurance we must have copies of all insurance.
Please bring copies of all insurance cards to your appointment.

Missed Appointment and HIPAA Policy

In an effort to improve access for all patients, Rivers Edge Family Medicine will actively work to reduce missed appointment activity, or no show appointments. We aim to provide the best quality of care for our patients. To ensure our patients do not miss their appointments, REFM makes appointment reminder phone calls the day before your schedule appointment. Please listen to your voice mails. Please make sure that all of your contact information is up-to-date each time you check in for an appointment. This is your responsibility. Please notify REFM of any cancellations within 24 hours of your scheduled appointment time. This will allow our office enough time to fill the appointment slot with another patient in need. If you cancel within less than 24 hours of the scheduled appointment, it will count as a missed appointment. New patient's missing their first appointments will not be allowed to reschedule. All missed apppointments will be charged a fee. Missed physicals will be charged $100.00 and most other appointments will be charged $50.00. The fee must be paid before you can schedule another appointment.

Out of respect for other patients and your providers time, there is only a 5 minute grace period for being late. You will be asked to reschedule and pay the fee's mentioned above. This is an office policy and no exceptions will be made.

Witness Signature Date Insurance Authorization and Assignment (Please Read)

I authorize Rivers Edge Family Medicine to provide any applicable personal and medical healthcare information contained in my records for my treatment, account balance resolution and other healthcare operations to appropriate agencies, including collection agencies, insurance companies and third party payers. I CERTIFY THAT I AM THE PERSON NAMED ABOVE OR THE LEGAL GUARDIAN OF THE PATIENT and agree to pay for all fees and charges for my treatment and services provided. I understand that should I default on payment of my account and collection agencies are required, all cost of collections up to 40% of the balance, including attorney/court costs will be added to the balance of my account.

Receipt of Notice of Privacy Practices (printable on-line and available in the office)

I have been offered the HIPAA Notice of Privacy Practices at Rivers Edge Family Medicine which outlines my privacy rights and how REFM may use and discose Protected Health Information about me.

Please circle one: Yes No Offered but declined **Your Initials:** _____

Patient/Responsible Party Signature: _____ **Date:** _____

RIVERS EDGE FAMILY MEDICINE

Patient Name: _____ **DOB:** _____

Agreement of Financial Responsibility

Thank you for choosing Rivers Edge Family Medicine (REFM) as your health care provider. REFM is committed to providing quality care and service to all of our patients. The following is a statement of REFM's financial policy, which we require that you read and agree to prior to receiving any treatment from REFM.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. REFM accepts cash, check, credit cards, and pre-approved insurance for which REFM is a contracted provider.

Self pay patients are expected to pay at time of service so that we can continue providing care to you. This means that at the time of service you will be paying by cash, check, or debit/credit card. We will not bill insurance for services provided under this arrangement.

It is your responsibility to know your own insurance benefits, including:

REFM will not attempt to confirm your insurance coverage prior to your treatment. It is **YOUR** responsibility to provide current and accurate insurance information to REFM, including any updates or changes in your insurance coverage. Should you fail to provide this information, **you** will be financially responsible for the costs of the services rendered by REFM.

If REFM has a contract with your insurance company, REFM will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If REFM does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. REFM will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. REFM will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

We asked you to arrive 15 minutes early so we can update your information and get you back to your appointment on time. If you are late seeing your provider then so are the patients after you. Please be courteous and be early! Anyone who is more than 5 minutes late you will need to reschedule your appointment and subject to a no show fee. Fortunately, our providers are amazing and loved by our patients, therefore you may have to wait a few days until an appointment is available. Appointments are valuable to everyone and there will be a late cancellation charge if you need to reschedule without a 24 hour notice.

I have read the financial policy stated above, and my signature below serves as acknowledgment of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

Signature of Responsible Party_____ Date _____

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

WHAT IS INCLUDED IN YOUR PHYSICAL TODAY?
THESE ARE YOUR INSURANCE GUIDELINES- NOT OURS

Many adults miss out on preventive screenings covered by their health plans at little or no out-of-pocket cost. These screenings identify and reduce your risk for diseases and prevent certain chronic conditions. Screenings you need are based on your age, gender and health history, getting screened regularly is worth a lifetime of good health.

WHAT *IS* INCLUDED IN AN ANNUAL WELLNESS VISIT PER INSURANCE GUIDELINES? HERE ARE SOME EXAMPLES, IF APPLICABLE:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Depression Screening
- Diabetes Screening
- HIV Screening
- Immunizations
- Prostate Cancer Screening
- Sexually Transmitted Screening
- Tobacco Use Cessation Counseling

WHAT'S *NOT* INCLUDED IN AN ANNUAL WELLNESS VISIT PER INSURANCE GUIDELINES AND WILL GENERATE AN ADDITONAL OFFICE VISIT. HERE ARE SOME EXAMPLES:

- **Not** Medication Refills
- **Not** Illness/Sick Visit
- **Not** Chronic Conditions, a few examples:
    - Asthma
    - COPD
    - Arthritis
    - Alzheimer disease and dementia
    - Heart Disease
    - HIV
    - Mood Disorders (bipolar and depression)
    - Epilepsy
    - High Blood Pressure
    - High Cholesterol

You may decide to schedule a separate appointment to discuss topics that are not covered under your insurance plan during your wellness visit. But if you would prefer to avoid scheduling another appointment, we will address any additional health needs at the same time as well as your wellness visit. In this instance, you will be charged a copay and/or a deductible.

In advance of your appointment, we encourage you to consult with your insurance provider If you have questions or concerns about your coverage.

*****PLEASE READ THIS IN ITS ENTIRETY: _____ Initials: _____**

(Print name)

RIVERS EDGE FAMILY MEDICINE

Adult Comprehensive Patient History

☐ New Patient ☐ Established Patient

Name:_____ D.O.B_____ Age:_____ Date:_____

Past History: *Check all that apply*

- ☐ Acid reflux
- ☐ Alcohol or Drug problems
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Emphysema
  - ☐ Other lung disease
- ☐ Esophagitis, ulcers
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Stroke
- ☐ Thyroid diseases
- ☐ Vein problems

☐ Other diseases not listed _____

☐ Explain any of the above if necessary _____

_____

_____

☐ Hospitalizations _____

_____

Surgery/Procedures: (*check all that apply*) *PLEASE ADD APPROX DATE(S): MONTH AND YEAR*

- ☐ Appendix
- ☐ Bladder suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial (ovaries preserved)
- ☐ Joint Replacement
- ☐ Orthopedic surgery
- ☐ Prostate surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy

☐ Other surgery not listed above _____

☐ Significant injuries _____

Medication List:

Name of medication, vitamin, OTC supplements or herbal medicine	Dosage	Supplies	Times/day	Disease or Reason

Medication allergies or reactions:

Medication	Reaction	Medication	Reaction
1		2	
3		4	

Name:_____

Family History:

Family Member	Date(s) of Birth	Living	Deceased	Diseases
Father				
Mother				
Brother(s) #				
Sisters(s) #				

Diseases in the family: Check all that apply

☐ Arthritis ☐ Addiction problems ☐ Bleeding Problems

Cancer(s) ☐ Colon ☐ Breast ☐ Prostate ☐ Other type of cancer(s) _____

☐ Depression/Anxiety ☐ Diabetes ☐ Heart disease ☐ High blood pressure

☐ High cholesterol ☐ Kidney disease ☐ Liver disease ☐ Mental illness

☐ Other

☐ Details / Other _____

_____

Social History:

Married? ☐ NO ☐ YES Divorced? ☐ NO ☐ YES Children? ☐ NO ☐ YES If yes, number of children _____

Family members living in the home: ☐ Mother ☐ Father ☐ Siblings ☐ Others: _____

Do you smoke? ☐ Currently ☐ Past ☐ Never _____ packs/day for _____ years. Other tobacco use? ☐ NO ☐ YES

If you do smoke, would you like information about our smoking cessation program? ☐ NO ☐ YES

Do you drink alcohol? ☐ NO ☐ YES ☐ Beer ☐ Wine ☐ Liquor. How many drinks per week? _____

How many servings of caffeine per day? _____ ☐ Coffee ☐ Tea ☐ Sodas

Do you limit salt in your diet? ☐ NO ☐ YES Do you limit fat? ☐ NO ☐ YES

Any illegal drug use? ☐ NO ☐ YES Type _____

Occupation _____Any known occupational exposures? _____

Do you exercise regularly? ☐ Yes ☐ No If so, how many times per week? _____ Type of exercise _____

Do you feel safe in your home? ☐ NO ☐ YES

Sexual Orientation? ☐ Not Applicable ☐ Heterosexual ☐ Homosexual

Preventative Care:

Date of last Colon and Rectal Cancer screening: _____ ☐ Rectal exam ☐ Sigmoidoscopy ☐ Colonoscopy

Date of last eye exam: _____ Have you had bone density (DEXA) exam? ☐ NO ☐ YES Date: _____

Do you use your seat belt? ☐ Yes ☐ No

Immunizations:	Date	**Immunizations:**	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles	
Whooping cough		HPV	

For our FEMALE patients only:

Do you have a Gynecologist? ☐ Yes ☐ No If yes, Gynecologist name: _____

Date of last PAP test _____ Date of last mammogram _____ Do you do self-breast exams? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No

Menstrual or period problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____

Number of pregnancies _____ Number of live births ____Vaginal ____ C-section ____ Miscarriages ____ # of abortions _____

Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

_____

For our MALE patients only: Date of last PSA test _____ Date of last rectal exam_____

Name:_____

Review of Systems:

Please indicate any problems in the following areas that are bothering you. If your planned visit is for a Preventative Physical, please be aware that another office visit may need to be scheduled to address new specific issues in appropriate detail.

Check all that apply:					
Constitutional:	☐ Fever	☐ Chills/Sweats	☐ Weight gain / Loss	☐ Fatigue	☐ Weakness
	☐ Poor appetite	☐ Appetite change			
Eyes:	☐ Blurred vision	☐ Double vision	☐ Eye pain		
Ears:	☐ Ear pain	☐ Decreased hearing	☐ Dizziness (light headed, room spinning)	☐ Ringing	
Nose:	☐ Congestion	☐ Sinusitis	☐ Difficulty breathing through nose	☐ Frequent nose bleeds	
Throat:	☐ Sore throat	☐ Sensation of fullness	☐ Difficulty swallowing		
Neck:	☐ Neck pain	☐ Fullness or lumps			
Cardiovascular:	☐ Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise			☐ Heart palpitations	
	☐ Heart racing	☐ Shortness of breath while lying down or with exertion (out of proportion to activity)			
	☐ Swelling of legs	☐ Fainting			
Pulmonary:	☐ Cough	☐ Emphysema (COPD)	☐ Shortness of Breath	☐ Asthma	
GI:	☐ Nausea	☐ Vomiting	☐ Abdominal pain		
	☐ Heartburn	☐ Sudden fullness	☐ Hemorrhoids		
	☐ Diarrhea	☐ Constipation	☐ Blood in stool	☐ Change in frequency of stools	
Genitourinary:	☐ Pain with urination	☐ Increased frequency of urination		☐ Frequent nighttime urination	
	☐ Blood in urine	☐ Sexual problems	☐ Difficulty with erections	☐ Vaginal pain	
	☐ Vaginal discharge	☐ Slow stream/dribbling	☐ Incontinence		
Musculoskeletal:	☐ Joint pains	☐ Muscle weakness	☐ Muscle pain	☐ Back pain	
Skin:	☐ Rash	☐ Sores	☐ Moles that are changing	☐ Itching	☐ Dry skin
	☐ Eczema	☐ Have seen dermatologist in past year	Dermatologist's name: _____		
Neurological:	☐ Headaches	☐ Numbness/Tingling	☐ Weakness	☐ Speech abnormalities	
	☐ Fainting	☐ Memory Problems	☐ Imbalance/vertigo	☐ Headaches	☐ Tremors
Psychological:	☐ Anxiety	☐ Eating disorder	☐ Obsessive behavior	☐ Depression	☐ Unusual fears
	☐ Mood swings	☐ Crying spells	☐ Lack of motivation	☐ Drug dependence	
	☐ Alcohol problems	☐ Insomnia	☐ Panic attacks	☐ Anger/Rage	

In the last 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ NO

In the last 2 weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ NO

Do you have Advanced Directives (Living Will, Durable Medical Power of Attorney)? ☐ Yes ☐ NO

Reviewed with patient on _____ Signature _____