

Rivers Edge Family Medicine

Legal Name: _____ Date of Birth: _____

Preferred Name: _____ Age: _____

Email: _____ Patient Portal Invite: Yes or No

Phone Number: _____ OK to leave Health Information on Voicemail? Yes or No

Preferred Pronouns (please circle all that apply): He/Him She/Her They/Them

Legal Gender: _____ Preferred Gender (if different from legal): _____

Please fill out the Next Section if Patient is a Minor

**Custodial Name(s): _____

**Phone Number(s): _____

**Who is with the patient today? _____ Relationship to Patient: _____

**Address: _____

Emergency Contacts

Name: _____ Relationship: _____

Phone: _____ May we share health information w them? Yes or No

Name: _____ Relationship: _____

Phone: _____ May we share health information w them? Yes or No

Name: _____ Relationship: _____

Phone: _____ May we share health information w them? Yes or No

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

Race: _____ Ethnicity: _____ Preferred Language: _____

Or check this box if you refuse to provide this information: []

Pharmacy

Preferred Pharmacy Name: _____ Phone: _____

Address: _____

Preferred Pharmacy Name: _____ Phone: _____

Address: _____

Would you like a copy of your HIPAA Notice of Privacy Rights?

If so, please let the front staff know. Thank you!

I verify all my Information above is accurate & filled out completely.

Patient or Guarantor Signature: _____ Date: _____



Patient Acknowledgment and Payment Responsibility

Rivers Edge Family 4626 Sawmill Rd, Columbus, Ohio 43220 614.538.9339

Our goal is to work together, with you, to provide you the best medical care we can and have you use your insurance benefit to the fullest.

- You acknowledge all Auto Accident appointments are self-pay. No exceptions.
- You acknowledge that we do not see any BWC (Workman's Comp) Claims. We are not licensed. You need to contact your HR dept to find out where to go. No exceptions.
- If you do not have proof of your insurance at the time of your visit, or we cannot verify properly, you may be asked to pay for your appointment.
- We may not be in network with your insurance. It is not REFM's responsibility to find out if your insurance is in network with our office. We will not call your insurance to verify coverage. **IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE INFORMATION.**
- Should you fail to provide REFM with your current insurance before your insurance's timely filing deadline, you will be fully responsible for the costs of the services rendered by REFM.
- If you are asked to schedule an appt to go over lab or test results, you may incur a fee.
- If you have a Medicaid Plan that we are not in network with and still choose to go here, willingly, and knowingly, that you can have services fully covered by a different provider, other than one at REFM, you will be responsible for payment.
- All injection fees for medication, that is prescribed to you by REFM, may result in an injection fee that is due at the time of service.
- If your COB (coordination of benefits) has not been updated and insurance denies the date of service, you may be responsible for payment.
- If you are a non-Medicare patient and want an early Annual Well Physical, prior to our guidelines at REFM and most insurances have, of the 365 days + 1, your insurance may not cover your appointment and you may be responsible.
- If you are having your Annual Well Physical, only specific topics are covered by a routine Annual Well Physical. If you choose to speak about other topics that are not included in what your insurance deems as your Annual Well Physical, such as medications, sickness, or chronic conditions, etc, you may either be asked to schedule another appointment to cover those items or you may be responsible for payment for those items per your insurance.
- Services rendered at REFM only covers services performed by your provider at REFM- NOT any labs done here, by Path Group. They are a separate company. Services will be billed separately.
- If you are self-pay for today's visit, then you are responsible for paying, in full, for today's visit. Leaving without payment, may result in not having medication sent in or being able to schedule another appointment.
- If you do not show up for your appointment or cancel late for your appointment you may be asked to pay a fee before you can reschedule.
- If you show up late for your appointment, you may be asked to reschedule your appointment. Please show up 10-15min prior to your appointment so we can make sure you are checked in correctly.

Signature of Patient_____ Date_____

Printed Name of Patient_____

If patient is a minor, Signature of parent or legal Guardian_____

Relationship to Patient, if not the patient_____



Missed Appointment Policy & Notice of HIPAA

4626 Sawmill Rd, Columbus, Ohio, 43220 614.538.9339

In 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 care for our patients.

*** To ensure our patients do not miss their appointments, REFM makes their patients eligible for phone, text, or email reminders prior to your appointment, if scheduled 2 days prior to your appointment.**

*** Please listen to your voicemails, read your texts, or read your emails concerning your scheduled appointment. This is your responsibility.**

*** Please notify REFM of any cancellations 24 hours prior to your scheduled appointment.** This will allow our office enough time to fill the appointment slot with another patient in need.

*** If you cancel less than 24 hours of your scheduled appointment time, it may count as a missed appointment.**

*** New patient's missing their first scheduled appointment may not be allowed to reschedule.**

*** All missed appointments may be charged a fee that will need to be paid prior to scheduling another appointment.** Fees are subject to change at any given time.

*** We ask that you arrive 10-15 minutes prior to your scheduled appointment time** so you can be checked in to your appointment correctly and taken back for your appointment so your provider can have the allotted scheduled time for your appointment.

*** Out of respect for other patients & your providers time, there is Only a 5 Minute Grace Period for being late. You may be asked to reschedule & may be asked to pay the fee mentioned above. This is an office policy and no exceptions will be made.**

Witness Signature Date Insurance Authorization & Assignment (Please Read)

I authorize Rivers Edge Family Medicine to provide any applicable personal & medical healthcare information contained in my records for my treatment, account balance resolution, & other healthcare operations to appropriate agencies, including collection agencies, insurance companies, & 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 & charges for my treatment & services provided by Rivers Edge Family Medicine. 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 disclose Protected Health Information about me.

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

I have read, acknowledge, & understand all the above information.

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

Rivers Edge Family Medicine Screening Questions

Name: _____ DOB: _____ Today's Date: _____

Your insurance may require screening tests to be completed.

Please fill out your medical history for the following tests, to the best of your knowledge.

Smoking Status:

Do you Smoke? Yes or No

Former Smoker: How long did you smoke? _____ Quit date _____

If yes, please circle your best answer below:

1: Current Every day or Current Some days

2: On average how much do you smoke daily?

Less than 1 pack daily one pack per day 1.5 packs per day 2 packs per day 2+packs per day

Colorectal Screening:

Have you had a Screening Colonoscopy? Yes or No Have you done a Cologuard? Yes or No

If yes: Date of Completion _____

Name of Medical Facility, City, and State: _____

Screening Mammogram:

Have you had a Screening Mammogram? Yes or No Not Applicable

If yes: Date of Completion _____

Name of Medical Facility, City, and State: _____

Pap Smear:

Have you had a Screening Pap Smear? Yes or No Not Applicable

If yes: Date of Completion _____

Name of Medical Facility, City, and State: _____

Eye Exam:

Have you had an Eye Exam? Yes or No

If yes: Date of Completion _____

Name of Medical Facility, City, and State: _____

Dental Exam:

Have you had a Dental Exam? Yes or No

If yes: Date of Completion _____

Name of Medical Facility, City, and State: _____

Bone Density Scan:

Have you had a Bone Density Scan? Yes or No

If yes: Date of Completion _____

Name of Medical Facility, City, and State: _____

Tdap/Tetanus Vaccine:

When was your last Tetanus Vaccine: _____

Thank you for taking your time to complete your forms. We appreciate YOU!

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'S *NOT* INCLUDED IN AN ANNUAL WELLNESS VISIT PER *YOUR* INSURANCE GUIDELINES AND WILL GENERATE AN ADDITIONAL 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

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

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)