Riverwood Medical Clinic
489 Agnes St. Ste. 100
BASTOP, TEXAS 78602
PHONE: 512-321-9091 Fax: 512-549-3005

Last Name First Name M.I. Date of Birth	Sex (circle) Age: Male/Female
Mailing Address Apt./LOT City State/Zip	**SS#**
Child Lives With: Mother/Father or Other (Specify)	Parent/Guardians Name (if under the age of 18)

Home Phone ( )	Work Phone ( )	Mobile Phone ( )	**Email Address**

Race(circle) Black – White – Asian – Hispanic – Other:_____	**Ethnicity (circle)** Hispanic – Non-Hispanic – Unknown

Parent, Guardian or Spouse of Patient

Last Name First Name	Address City State/Zip
Home Phone ( ) Work Phone ( )	Mobile Phone ( ) **How may we contact you? Please Circle One** Mail Text Email Call **May we leave a detailed message?** Yes or No

Insurance Information- your insurance cards are requested at this time

Primary Carrier Insurance Company Effective Date	Insurance Carrier Mailing Address City State/Zip
Insurance Carrier Mailing Address City State/Zip	Policyholder Name
Policyholder Name	Policy # Group #
Policy # Group #	Policy # Group #

Name of Person who Carries the Insurance for the Patient

Head of Household or Parent with Custody of Minor	DOB

Last Name: First Name: Address: SS# Relationship:	Phone # Home ( ) Work ( ) Mobile ( )

Please Circle Preferred Pharmacy: CVS, WALGREENS, HEB, WALMART, OTHER_____

Assignment of Benefits

I hereby authorize direct payment of medical and diagnostic benefits to R.M.C., for services rendered in person or under supervision. I understand that I am financially responsible for any amount not paid by the insurance company. Dependent patient must sign if not a minor. Initial _____

Authorization to Release Information

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I certify the information I furnished is true and correct. I understand it's a crime to fill out this form with facts I know are false or leave out facts I know are important. Initial _____

Consent for Treatment

I hereby voluntarily authorize and consent to such medical care encompassing diagnostic procedures and treatment by my attending practitioner, his or her associates, assistants and other health care providers, as may be necessary in his or her judgment. I have relied on my attending practitioner for information in this regard and acknowledge that no warranty or guarantee has been made to me as to result or cure. Initial _____

Receipt of Notice of Privacy Practices

I, (print patient name) _____, have read a copy of Riverwood Medical Clinic's Notice of Privacy Practices. (This document is available at the front desk or on our website.) Initial _____

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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Medical Health History

Name:	**DOB:** **Age:_____**
Allergies:	
Preferred Pharmacy:	
Reason for visit today:	
Please review the below list, and check any problems that you currently have or have had in the past.	

Medical History

- Abnormal Pap Smear
- Acne
- Adult ADD
- Anorexia
- Anxiety Disorders
- Atrial Fibrillation
- Anemia or Blood Problems
- Arthritis
- Asthma
- Back Problems
- Bipolar Disorder
- Birth Defects
- Blood Transfusion
- Blood Clot
- Breast Cancer
- Chronic Bronchitis
- Cancer/Tumor
- Chicken Pox
- Colon Disease
- COPD, Emphysema, Lung Disease
- Crohn's Disease
- Colon Polyps
- Depression
- Diabetes: Type1____ Type2____
- How Long_____
- Diphtheria
- Drug or Alcohol Abuse
- Epilepsy (seizures)
- Fibromyalgia
- Glaucoma or Cataracts
- Headaches: Type _____
- Hearing Loss
- Headaches: Type_____
- Heart Disease or Heart Attack
- Hepatitis A,B,C or Jaundice
- HIV or AIDS
- Hypertension (High Blood Pressure)
- Hypothyroid/Hyperthyroid
- Inherited Disease
- Kidney Disease or Stone
- Measles
- Mumps
- Mental Illness or Depression
- Abnormal Pap Smear
- Peptic Ulcer Disease
- Pneumonia
- Polio
- Rheumatic Fever
- Scarlet Fever
- Sexually Transmitted Disease (STD)
- Sickle Cell Anemia or Trait
- Skin Disease, Eczema, Psoriasis
- Small Pox
- Stroke
- Tuberculosis

- Other:_____
- Other: _____

Please list any ALLERGIES below and type of reaction:

_____

_____

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Consent for Treatment, Payment, and Health Information

Riverwood Medical Clinic (R.M.C.) is an independent, for –profit medical facility. Payment for services is due at the time of your visit. You are responsible for any co-pays or non-covered service charges that occur. It is your responsibility to know your health plan-covered benefits. We are enrolled in all the major healthcare plans, but our contract with them may change without notice. If we are currently a contracted provider for your plan, we will verify your eligibility at the time of your visit.

By signing below, you are granting consent for R.M.C. to use your protected health information for the purposes of treatment, payment and health care operations. You are also declaring that you have reviewed our posted Privacy Practice Notice and agree with its terms and conditions. You are giving consent to R.M.C., Providers and staff to perform treatment for your medical problem or condition. You understand that we are not a hospital based medical facility and that we are not legally bound to provide series for any particular, or every medical problem you present to R.M.C. today. We retain the right to deny services as our professional and medical judgment may dictate.

****NOTE****

We are **not** chronic **pain** treatment **specialists**. We retain the right to deny treatment of chronic pain problems with narcotic or other controlled substances. Our primary goal is that every one of our patients be attended to with the best professional practices available. We encourage you to notify us in writing with any complaints you may have, so that they can be addressed and handled in a timely manner.

Finally, the patient is solely responsible for making sure to follow up on any lab or X-Ray results that are ordered by our facility. We cannot guarantee that study results of test done out of our facility will get back to us. You agree to contact our clinic if you do not hear about your test results in a timely manner.

Patient signature: _____ Date: _____

Legal Guardian: _____ Date:_____

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No Show/ Same Day Cancellation Fee

Patient Name: _____

Last First M

Date: of Birth: _____/_____/_____

It is the policy of "Riverwood Medical Clinic" to optimize the use of physician's clinic time by working to ensure that scheduled time blocks are filled by schedule patients. Patient guarantors who do not provide the clinic with at least one (1) day- 24 hour notice of cancellation will be charged a $25.00 "No Show/ Same day cancellation" fee for missing a confirmed appointment. This charge will be collected at the next visit and a statement will be mailed to your home address that was given on the patient demographic form.
Riverwood Medical Clinic has an answering service for patients to leave a cancellation message with if needed. We also have demand-force that you can email us of any cancellations.

Riverwood Medical Clinic physicians reserve the right to discontinue patient care when an established patient misses three (3) confirmed appointments without providing one (1) day- 24 hour notice of cancellation.

Patients will be notified in writing that a third missed appointment will result in termination of the physician/patient relationship. When a new patient misses two (2) confirmed appointments, that patient will not be able to be seen at our clinic at any future time.

Thank you for your cooperation.

Signature of Patient or Guardian: _____

Date: _____

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Our Financial and Office Policies

Thank you for choosing Riverwood Medical Clinic (R.M.C.) as your healthcare provider. We are committed to providing our patients with the best available medical care. Our staff will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and sign our financial and office policies and complete the patient information form prior to seeing the physician. As you read, please initial beside each topic to indicate your understanding of our policies.

____1. All co-pays, deductibles, and /or co-insurances are due at time of service. We do not choose these fees. They are provided to our office by your insurance company when we call to verify benefits and/or the terms agreed upon by you (your employer) and the insurance company.

____ 2. We verify insurance benefits as a courtesy to our patients. All charges are <u>your responsibility</u> whether, your insurance company pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have questions regarding your health care coverage. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to reviving services. You are ultimately responsible for all charges that are not covered under your health care policy.
Please remember that your insurance is a contract between you (your employer) and the insurance company. We are not a party to that contract.
It is very important that you understand the provisions of your healthcare policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, any contact or explanation should be made to you, the policy holder. Reduction or rejection of any claim by your insurance company does not relieve you of your financial obligation. In the event that your insurance company pays us for a claim that you had already paid and you are due a refund, we will be happy to expedite your refund or credit your account with in ten (10) days.

____3. We will collect all co-payments, deductibles or charges for non-covered services at check in. If you have a balance on your account we will ask for that payment as well. For your convenience, we accept cash, check, Money Order, Care Credit and all Major Credit Cards. We will be more than happy to assist you in applying for Care Credit.

____4. We allow a maximum of 90 days for payment of any balances that are responsibility of the patient. If we do not receive full payment in 90 days, the account will be referred to collections. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.

____5. Please ensure that all personal and insurance information is correct at the time of each visit. We will only bill the insurance company on file. It is not uncommon for someone to change their phone number or address and forget to inform us. This leads to fragmented communications. Please inform the front office staff if your phone number, address or insurance has changed (or if you anticipate that it will be changing in the near future).

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____6.a Appointments not canceled with a 24 hour notice and any "no show" appointments will be subject to a charge of $25.00. Please note that this fee is not covered by your insurance company. We sincerely hope that we will not need to collect this fee. Rather, it is offered as an incentive to remind all of our patients and families to keep their scheduled appointments or, if unable to keep that appointment, to please reschedule more than 24 hrs. In advance (and we greatly appreciate 48-72 hrs. advance notice). When you reschedule your appointment several days ahead of time, this allows other patients the opportunity to be seen sooner… which they often greatly appreciate.
____6.b any diagnostic or therapeutic service appointments (IE: EKG, Ultra Sound, Echo, BMD or Pulmonary Function Testing) not canceled with a 24 hour notice, will be subject to a charge of $50.00. The patient may not be more than 10 min late for such appointment anything over that we will need to reschedule the appointment and a $25.00 charge will be added to the account.

____7. After (3) three "NO SHOW" appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party. Should the physician choose not to terminate the relationship, we reserve the right to charge a $35.00 deposit for any future appointments. The deposit can be applied to any copay, co-insurance or deductible due at time of service or the deposit will cover the cost of the "NO SHOW" fee.

____8. If you are more than 10 min late for your appointment, we will reschedule your appointment.

____9. Any personal check returned for insufficient funds, will be charged $35.00 in addition to the amount of the check. After on instance of a returned check, all further payments will be required to be in the form of Cash, Credit Card, Care Credit or Money Order only.

____10. FMLA paper work. Please note that we do our best to get this done in a timely manner and we ask for your patience. We require 3-5 business days to complete the paper work.

____11. There is a fee for copies of medical records not requested by another physician. The fee is $25.00 for the first 20 pages and $.50 each additional page. For affidavits there is a $15.00 charge. The patient, parent or guardian must complete an authorization to disclose health information and the $25.00 fee will be collected before the records will be released.

____12. ALL prescriptions refills MUST be called directly to your pharmacy. For your convenience, we transmit e-prescriptions via a secured internet network directly to participating pharmacies. You can have your pharmacy submit the refill request electronically. WE DO NOT accept calls directly from patients for refills. Please do not wait until you are out of medication before checking to see if you have refills on file. **You will be required to schedule a refill visit every three months and be sure to bring all your bottles with them to every appointment.**

____13. NOTE: IF ANY PATIENT IS ON A **CONTROLLED MEDICATION** WE WILL SEARCH THE DPS WEBSITE TO SEE IF ANY OTHER PROVIDERS ARE BEING USED**. You will be required to come in once a month for a visit to receive your prescription.**

I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES

_____ _____
Signature of patient (or responsible party **Date**

_____ _____
Printed name of patient (or responsible party **Witness**

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Permission to Verbally Discuss Protected Health Information

***Note: Completion of this form is optional. To be valid, this form must be filled out COMPLETELY, including what information you are giving us permission to share.**

Patient Name: _____Date of Birth: _____

I give permission to Riverwood Medical Clinic (RWMC) to VERBALLY discuss the following medical and billing information about me (check all boxes that apply):

☐ Scheduling/appointment information

☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan. This may also include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDs testing and treatment, pregnancy testing, prenatal care, birth control and family planning.

☐ Behavioral health information, including my symptoms, diagnosis, medications, and treatment plan

☐ Chemical dependency information, including my symptoms, diagnosis, medications, and treatment plan

☐ Lab/test results

☐ Billing and payment information

☐ Other:

_____

RWMC has my permission to discuss the above information with:

Name	Phone	Relationship to Patient

I understand that I may cancel this permission at any time (by writing to RWMC Health Information), but that cancelling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

This authorization expires:

☐ When I cancel it in writing ☐ _____ (specify date)

If no expiration date is specified, this authorization will remain in effect until RWMC Medical Records receives written notice to cancel it.

☐ I decline permission to verbally discuss medical information.

_____	_____	_____
Signature of patient/guardian	Date	Relationship to patient
_____	_____	_____
Witness if patient is unable to sign	Date	Reason patient is unable to sign

If authorized representative, please sign and attach copies of supporting legal documentation.

***Note: A minor patient's signature is REQUIRED (for ages 13 and above) for us to share information about care for (1) conditions relating to the minors sexuality including, but not limited to: family planning and sexually transmitted diseases (2) alcoholism and/or drug abuse; and (3) mental health conditions.**