Riverview
FAMILY MEDICINE
& URGENT CARE

PATIENT INFORMATION
Private

	Patient	Responsible Party - *if different than patient* Patient Relationship ☐ Child ☐ Other _____
Today's Date	____ /____/ 20___	
Legal First Name, Middle		
Legal Last Name		
Date of Birth		
Gender	☐ Male ☐ Female	☐ Male ☐ Female
Social Security #		

Mailing/Street Address		
Apt/Bldg/Suite#		
City, State, Zip Code		

Home Phone	( )	( )
Cell Phone	( )	( )
Work Phone	( )	( )
E-mail address		

Preferred Language	☐ English ☐ Spanish ☐ _____
Race	☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Chinese ☐ Filipino ☐ Japanese ☐ Native Hawaiian or other Pacific Islander
Ethnicity	☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

		Primary Insurance - *if applicable*	Secondary Insurance - *if applicable*
Name of Insurance			
Primary Policyholder	Name		
	Date of Birth		
	Gender	☐ Male ☐ Female	☐ Male ☐ Female

1. Emergency Contact _____ **Relationship to Patient** _____ **Phone** ( ) _____

2. Preferred Pharmacy and Location _____

3. Who is your Primary Care Physician (PCP) (Physician that provides annual physicals and preventive medicine screenings for you)?

☐ n/a **or** Doctor Name and/or Practice Name _____

City _____ State _____ Phone # *(if known)* ( ) _____

4. If we are not your PCP, would you like notes from today's visit forwarded to your Primary Care Physician (PCP)? ☐ yes ☐ no

5. ☐ If you do not currently have a PCP and you would like for us to be your primary care physician, please check here and we will direct your care towards annual physicals, labwork and preventive screenings in compliance with the American Medical Association guidelines and establish you as a Primary care patient after your first appointment with a PCP. (Please know that we are unable to be Primary Care providers for some patients with certain insurance plans or physical conditions.)

Riverview
FAMILY MEDICINE
& URGENT CARE

PATIENT AUTHORIZATION

Private

Name: _____ **Date of Birth:** _____

CONSENT FOR EVALUATION AND TREATMENT **Reason for Today's Visit:** _____

I hereby authorize Riverview Family Medicine & Urgent Care (which for purposes of this authorization includes its affiliates, physicians, employees, and designate agents, hospitals or laboratories) to perform a physical examination and/or any medical treatment deemed necessary by the treating physicians. These may include, but not be limited to, any required medical examination, x-rays, past Rx history, medical procedures and medical, diagnostic or laboratory tests ordered by the center physician(s) to be carried out by the designated center staff. I understand certain special medical evaluations performed by Riverview such as pre-placement, annual, or executive physical exams, school/sports physical exams, and other similar services are not intended to replace the medical care of my personal physician and are not intended for purposes of medical diagnosis and/or treatment. **Initials:** _____

ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT (Not applicable to Workers' Compensation)

I hereby authorize and assign to Riverview any and all benefit payments for services rendered under the terms of my insurance policies, and hereby individually obligate the payer to pay the account to Riverview in accordance with the standard and customary charges incurred during my period of treatment. I understand I am responsible for all deductibles, co-pays and charges for services rendered to me but not covered by my insurer. If I am liable for payment, a list of charges will be made available to me within thirty (30) days from the date Riverview becomes aware of my insurance ineligibility. Should the account be referred for collection, I understand I shall pay the collection expenses incurred by Riverview including, without limitation to, court costs and attorney's fees. I understand and agree to pay a $50 no-show/cancellation under 48 hours fee for missed primary care appointments. If you receive lab work today, you may also receive a bill from LabCorp who handles our outside specimen testing.

RELEASE OF INFORMATION / NOTICE OF PRIVACY PRACTICES

I hereby authorize Riverview to disclose to my insurance company or any third party payer (and/or my employer/prospective employer if found to be work-related) all medical information, test results and findings made during the course of this examination and/or treatment. I authorize the center to release any appropriate information concerning my medical history, examinations, treatments, or other diagnostic procedures, including copies of my records to official requesters. These include but are not limited to insurance companies, third party administrators, or utilization review organizations, healthcare service plans, or to any other person or entity as necessary in connection with certification, payment or reimbursement for services rendered. I acknowledge the medical information above may be released pursuant to the following paragraphs:

- It is the policy of Riverview to protect all medical records against loss, tampering, destruction and access by unauthorized persons. I understand medical records may be periodically reviewed by national accreditation or certification surveyors, on-site clinical pharmacy and other necessary quality assurance personnel and I authorize such release of information for these purposes only. I acknowledge my records and associated documentation may be disclosed to third-parties, including government agencies, as required by law, including, but not limited to, pursuant to a warrant, subpoena or court order, and I hereby agree not to pursue any action against Riverview for any damages I may suffer as a result of such disclosure.
- I acknowledge I have reviewed (either today or previously) the HIPAA Notice Of Privacy Practices.
- I elect to allow ☐ **No one** *or* ☐ **the following** to receive information regarding my medical treatment and care including (as indicated in box below):
  1. Appointment information, date, time and scheduling of visits
  2. Medical information discussed with my physician and/or copies of my medical records
  3. Test results, written or verbal
  4. Payment and billing information

Authorized Person	Relationship	Date of Birth	Information to be released (Check 1, 2, 3 and/or 4)
			☐ 1 ☐ 2 ☐ 3 ☐ 4
			☐ 1 ☐ 2 ☐ 3 ☐ 4
			☐ 1 ☐ 2 ☐ 3 ☐ 4

- In the case of contact from the clinics for follow-up information (test results, prescriptions, insurance info, etc.)...

My daytime phone # is ( ) _____ and you ☐ may or ☐ may not leave a message regarding my care.
My evening telephone # is ( ) _____ and you ☐ may or ☐ may not leave a message regarding my care.
You ☐ may or ☐ may not text me an appointment reminder at my cell phone # ( ) _____.

- This consent/authorization shall be in force and effect for **one year.** I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand if I choose to revoke my consent I must submit a written statement that it is signed by me and notarized. By signing this authorization form I acknowledge I have fully read or had this form read and/or explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and questions have been answered satisfactorily.

Patient Name: _____ Date: _____

Patient/Legal Representative Signature: _____ Relationship: _____

Riverview
FAMILY MEDICINE
& URGENT CARE

Primary Care Patients
Health History

Name _____
Today's Date ____ / ____ /_____
Date of Birth ____ / ____ / _____
Gender *(Circle One)* M F

Allergies

Are you allergic to any medications or other substances?

☐ *No* ☐ *Yes* *(If yes, please list below)*

_____

_____

Medications

Please list current medications including prescription, non-prescription, vitamins, allergy shots, etc. **or** ☐ **Please see attached list.**

_____

_____

_____

_____

_____

_____

_____

Medical Treatments, Hospitalizations, Surgeries, etc.

Please list any times/ reasons you have been in the hospital and date. Please include surgeries (inpatient and outpatient) and pregnancies.

_____

_____

_____

_____

Past/Current Illnesses & Conditions

Please check all that apply (if any)...

- ☐ add/adhd
- ☐ alcohol dependence
- ☐ anemia/blood transfusion(s)
- ☐ anxiety/depression
- ☐ asthma
- ☐ anxiety
- ☐ arthritis
- ☐ cancer (type)

_____

- ☐ diabetes
- ☐ emphysema or lung disease
- ☐ epilepsy/seizures/convulsions
- ☐ glaucoma
- ☐ hepatitis
- ☐ heart disease or problem
- ☐ hyper or hypothyroidism
- ☐ hypertension (high blood pressure)
- ☐ hyperlipidemia (cholesterol)
- ☐ kidney stones or disease
- ☐ leukemia
- ☐ pneumonia
- ☐ rheumatic fever
- ☐ sexually transmitted disease(s)
- ☐ stroke
- ☐ substance abuse
- ☐ tuberculosis
- ☐ ulcer(s)
- ☐ Other _____

Nicotine Use

- ☐ Current, every day
- ☐ Current, some days
- ☐ Former
- ☐ Never

Type: _____

Alcohol Use

- ☐ Yes
- ☐ No

___ drinks per day

or ☐ drink socially

Recreational Drug Use

- ☐ No
- ☐ Current
- ☐ Past

Regular Exercise

- ☐ Yes
- ☐ No

_____ times per week

Type _____

List of Specialists

_____

_____

_____

Screening/Immunizations

If you have had any of the following, please indicate the date last done...

mammogram _____
bone density _____
pap smear _____
flu vaccine _____
pneumonia vaccine _____
tetanus shot_____
colonoscopy _____
EKG_____
eye exam _____
covid vaccine _____

Family History

Please list details below or check here... ☐ **I am adopted and/or have no knowledge of biological family history.**

Mother

Age (if living) _____

Age (at death) _____

State of health or cause of death

- ☐ Anxiety/Depression
- ☐ Cancer (type)_____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hyper or hypothyroidism
- ☐ Hypertension/High Blood Pressure
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Other _____

Father

Age (if living) _____

Age (at death) _____

State of health or cause of death

- ☐ Anxiety/Depression
- ☐ Cancer (type)_____
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hyper or hypothyroidism
- ☐ Hypertension/High Blood Pressure
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Other _____

Riverview

FAMILY MEDICINE & URGENT CARE

LATE ARRIVAL/ NO SHOW POLICY

ANY PATIENT THAT ARRIVES MORE THAN 10 MINUTES PAST THEIR APPOINTMENT TIME WILL NEED TO BE RESCHEDULED.

ANY PATIENT THAT CANCELS THEIR APPOINTMENT WITH LESS 24HRS NOTICE WILL BE CHARGED A $50.00 FEE

ANY PATIENT THAT CANCELS AND RESCHEDULES THEIR APPOINTMENT ON THE SAME DAY OF THEIR APPOINTMENT, WILL BE CHARGED A $50.00 FEE

THE PROVIDERS AND STAFF APPRECIATE YOUR COMPLIANCE AND UNDERSTANDING SO THAT WE MAY CONTINUE TO PROVIDE EXCEPTIONAL CARE TO ALL PATIENTS

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Patient Name: _____ DOB_____

Please complete this form if you are seeing any specialist. This will help keep your records current. Thank you in advance!

Specialist's practice name: _____

Specialist's provider name: _____

Specialist's practice name: _____

Specialist's provider name: _____

Specialist's practice name: _____

Specialist's provider name: _____

Specialist's practice name: _____

Specialist's provider name: _____

Specialist's practice name: _____

Specialist's provider name: _____

☐ By checking this box, I agree that I am not seeing a specialist currently.

Patient Signature: _____ Date _____