Kids First Immediate Care

Red Cedar Valley Medicine, PLC

Registration Form

Patient Legal Name: First Middle Last Date of Birth:_____

Address: _____ Apt/Lot# _____

City: _____ State:_____ ZIP:_____

Reason for Visit: _____ ☐ Male ☐ Female Preferred Language: _____

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander

☐ White / Caucasian (i.e, European, Middle Eastern, North Africa) ☐ Bi-racial ☐ Other: _____

Ethnicity: ☐ Hispanic/Latino Country of Origin: _____

Responsible Party: _____ SS# (required) _____ DOB: _____

Address (if different from above): _____

City: _____ State:_____ ZIP:_____

Main Phone: _____ Wrk / alt: Phone: _____

E-mail: _____

Pharmacy: _____ Location: _____

Employer: _____ Phone:_____

Insurance #1:_____ Policy #:_____ Group#:_____

Policy Holder: _____ Policy Holder DOB:_____

Insurance #2:_____ Policy #:_____ Group#:_____

Policy Holder: _____ Policy Holder DOB:_____

How Did you Hear About Us? _____

Emergency Contact Information (Other than Responsible Party):

Name: _____ Relationship: _____

Main Phone: _____ Work / Cell Phone: _____

Release of Information

I authorize Red Cedar Valley Medicine, PLC (RCVM) to contact me using my electronic mail address provided above. I understand that electronic mail cannot be used to make, break, cancel or otherwise change appointments, nor can it be used for emergency medical services. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize RCVM, or its billing company, to file for benefits on my behalf for medical services rendered. Insurance payments shall be made directly to RCVM. If I have Medicaid, Medicare or TriCare insurance, I authorize RCVM to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for this or a related medical claims. I agree that I am financially responsible for all services not paid by insurance. This authorization is valid indefinitely until revoked by myself or by RCVM. I consent to medical treatment for myself or my minor child including medications and procedures that may be indicated for their diagnosis.

_____ _____

Parent or Guardian Signature Date Witness Signature Date

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
First Middle Last

Patient Address: _____
Street City State ZIP

Phone Number: _____

I authorize Red Cedar Valley Medicine, PLC (RCVM) to release information contained in my medical record (including if applicable, information and HIV infection or AIDS, information about substance treatment and information about mental health services)

Physician's or Agency's Name and Office Address to whom information may be released:

_____

_____

_____

Physician Phone Number: _____ Physician Fax Number: _____

Specific Type of Information to Be Disclosed:

□ Discharge Summary	□ History & Physical	□ Consultations
□ Laboratory Results	□ X-Ray Report and/or Film	□ Operative Reports
□ Pathology Reports	■ All Records History	□ Others (Specify) _____

The Purpose and Need for Disclosure: _____**Continued Care**_____

I give RCVM permission to release the information I have selected on this form to the individual(s) or agency(s) I have named for the purpose I have listed. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to RCVM. The revocation will take effect on the day it is received in writing and does not relate to any disclosure made before the revocation is received. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. Copies of the records may be obtained with reasonable notice and payment of copying costs, if applicable. Any revocation will not affect my ability to obtain treatment or payment or my eligibility for benefits. This form does not authorize re-disclosure of protected health information. This information could be subject to re-disclosure by the recipient and may then no longer be protected. I further understand that the person or entity that receives the information may not choose to obey federal privacy laws, and RCVM cannot be held responsible for any further disclosure.

This authorization is perpetual from the date of signature, until we have completed the disclosures you have requested, the patient becomes legally emancipated, or until you revoke the authorization, whichever is shorter.

Signature: _____ Date_____

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Notice of Privacy Practices – Patient Acknowledgment

Patient Name:_____ Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of protected health information that may be made by this practice, individual rights and the practices' legal duties with respect to protect health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclosure protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- Individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of protect health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information with reasonable charges.
    - The right to amend protected health information by adding notes.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient (if signed by personal representative of patient):_____

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Financial Policy

By signing this policy you agree that you understand:

1. **Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier.** We accept most debit, Discover, MasterCard and Visa credit cards.
2. **You agree to disclose to Red Cedar Valley Medicine, PLC all insurance coverage in effect at the time of service.** We will also need to know policy numbers, group numbers, the policyholder information and the guarantor information. Failure to do so may result in additional charges to you to cover costs incurred by us.
3. **That your insurance policy is a contract between you and your insurance company. We cannot interfere with that contract.** As a service to you, we will file your insurance claim and you assign the benefits to the doctor—in other words, you agree to have your insurance company pay the doctor directly.
4. **We have made prior arrangements with many insurance companies and health plans to accept an assignment of benefits.** If we have a contract with your insurance company, we will bill them for you, and you may be required to pay a copayment at the time of your visit or after the insurance company or health plan adjudicates your claim.
5. **If a plan or insurance company with whom we do not have a prior arrangement insures you, we will prepare and send the claim for you on an unassigned basis.** This means the insurer may send the payment directly to you. If this is the case, our charges for your care are due at the time of service.
6. **If we contract with an insurance company or plan, we must follow their master charge list and charge you the amounts they determine should be charged for services rendered.** We will not "discount," "adjust" or "write off" amounts your insurance company determines are allowed or should be paid by you.
7. **Not all insurance companies or plans cover all services.** In the event your insurance plan determines a service to be "not covered," you may be responsible for the entire charge. If you have an insurance plan with which we do not have a contract, you may be balance billed for any charges not covered by your plan. Payment is due upon receipt of an invoice from our office.
8. **If your insurance company or health plan does not pay the practice within a reasonable period, or in full, we will expect you to pay any outstanding charges.** If we later receive a check from your insurer, we will refund any overpayment to you.
9. **If a check is returned or not honored by your bank, you will be required to pay a $25.00 fee.**
10. **If we have to invoice you for an outstanding amount beyond the first invoice, you will be required to pay a $5.00 fee for the 2nd invoice, $10.00 for the 3rd invoice and $15.00 for each invoice thereafter.**
11. **If the amount owed Red Cedar Valley Medicine, PLC is not paid within three months of invoicing, the account will be sent to a collection agency.** You will then be required to pay an additional fee equal to 50% of amount owed, in order to cover our costs and inconvenience involved with obtaining payment.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient

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Health History

Patient Name: First Middle Last _____ **Birthdate:** _____ / _____ / _____

Up-to-date on immunizations? YES □ NO □ If not, what are they missing? _____

Any recent foreign travel? YES □ NO □ If so, where? _____

Current Medications & Dietary Supplements:

_____

_____

□ No current Medications

Drug Allergies AND the Reaction: _____

_____

_____

□ No Known Drug Allergies

Please list ALL surgeries and dates: _____

_____

Please list ALL serious accidents/injuries, hospitalizations, head injury or broken bones and dates: _____

Has the PATIENT personally been diagnosed with any of the following:

□ Allergies	□ Anemia	□ Asthma/RAD	□ Bladder Infection	□ Bronchiolitis
□ Chickenpox	□ Diabetes Type: □ 1 □ 2	□ Drug/Alcohol Abuse	□ Ear Infections	□ Eczema
□ GERD	□ Heart Disease	□ Hernia, Where?_____	□ High Blood Pressure	□ Infectious Mono
□ Kidney Disease	□ Measles	□ Migraines	□ Mumps	□ Pneumonia (recurrent)
□ Psychological Problems	□ RSV	□ Rheumatic Fever	□ Scarlet Fever	□ Thyroid: □ Hyper □ Hypo
□ Transfusions (blood)	□ Whooping Cough	□ Other _____		

Does the patient have any FAMILY (*siblings, parents, grandparents, aunts and uncle*) history of any of the following:

□ Allergies	□ Anemia	□ Asthma	□ Bleeding (excessive)	□ Cancer: _____
□ Chronic Lung Problems	□ Diabetes Type: □ 1 □ 2	□ Depression	□ Drug/Alcohol Abuse	□ Epilepsy
□ Glaucoma	□ Gout	□ Heart Disease	□ High Blood Pressure	□ High Cholesterol
□ Leukemia	□ Migraines	□ Obesity	□ Psychosis	□ Smoking
□ Stroke	□ Thyroid: □ Hyper □ Hypo	□ Ulcers (gastric)		

□ Other _____

Who resides in the home with the patient?

□ Father	□ Mother	□ Brothers #_____	□ Sisters # _____
□ Step-Father	□ Step-mother	□ Grandfather (P/M)	□ Grandmother (P/M)
□ Aunt	□ Uncle	□ Spouse / Domestic Partner	□ Other: _____

□ Pets: _____

Are there any SMOKERS that live in the home? □ No □ Yes: If yes, do they smoke inside the home? □No □Yes

Does the patient smoke? □No □ Yes: If yes, how many per day: _____

Does the patient consume caffeinated drinks? *(soda, coffee, energy drinks, tea, etc. (A drink is ≈ 8 oz))*

□ None	□ 1-2 drinks a day	□ 3-4 drinks a day	□ 4 or more a day

Does the patient consume alcoholic drinks? *(A drink is ≈ 8 oz)*

□ None	□ 1-2 drinks a week	□ 3-4 drinks a week	□ 4 or more a week

Is the patient in: □ Daycare □ Preschool □ Grade School □ Middle School □ High School □ College □ Other: _____

The best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary healthcare services I/my child may need.

Signature of Authorized Person: _____ Date: _____