



RIFE & ASSOCIATES

FAMILY HEALTH CARE

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

Address: _____ City/State/Zip: _____

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

Sex: _____ Social Security: _____ Marital Status: S M W D Sep Spouse: _____

Check if ok to leave message at:

Home Cell Work

How do you prefer to be contacted for your appointment reminder? (Check all you'd prefer)

Phone Text Patient Portal

Race: (Please Circle One) American Indian, Alaskan, Asian, African American, Caucasian, Hawaiian-Pacific Islander, Latino

Ethnicity: (Please Circle One) Hispanic or Non-Hispanic

Preferred Language: _____

Preferred Pharmacy: _____ **Location:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Responsible Party Name: _____ **Date of Birth:** _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Relationship:** _____

How did you hear about us? Thank you for your feedback!

Website Billboard Radio Newspaper Bus Ad Google Search Family/Friend
 Insurance Facebook Instagram Yelp Google Ad Other: _____

Assignment of Insurance Benefits: I hereby authorize direct insurance carrier payment of surgical/medical benefits to Dr. Rife and Associates Family Health Care, S.C. for services rendered by her/him in person or under her/his supervision. I understand that I am financially responsible for any balance not covered by my insurance

Authorization to Release Information: I hereby authorized Dr. Rife and Associates Family Health Care S.C. to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.

Medicare/Medicaid: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request payment of authorized benefits be made on my behalf.

Acknowledgement/acceptance of No Show/24 Hour Cancellation: I hereby agree to the terms that if I am not able to keep my schedule appointment and do not call to cancel my appointment with 24 hours prior to my appointment I will be charged a no show/24 hr. cancellation fee for that missed appointment. **A photo copy of these assignments shall be valid as the original.**

Patient Signature

Date

Relationship (if other than patient)



Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Rife & Associates Family Medicine (“the practice”) may use and disclose protected health information (PHI) about myself to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices before signing this consent.

Dr. Rife & Associates Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Robert Rife, Director of Operations, Dr. Rife & Associates Family Medicine, 10755 163rd Place, Orland Park, Illinois, 60467.

With my consent, the practice may mail to my home, or other designated location, any item(s) that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that the practice restricts how it uses/discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, and in accordance with Illinois law, Dr. Rife & Associates Family Medicine staff may call my home or other designated location and leave a message on voicemail, by text, or in-person to myself or any individual I list below to share my personal health information with, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including test results.

By signing this form, I am consenting to the practice’s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the consent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

Information Sharing: Please list any individuals that we can share your personal information with other than healthcare providers. (ex. Parents, spouse, friends, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please check box if you **do not** want your personal information shared with anyone.

Please check box if you **do not** want to be contacted by text

Patient/Guardian Signature

Date

Patient/ Guardian Name (Please Print)

Notice of Practice Policies

Appointment Confirmation and Special Charges

A call confirming your scheduled appointment will be made prior to your appointment. A message may be left on your answering machine/voicemail if no one answers the phone.

A \$50.00 NO SHOW FEE will be made to all patients who fail to show up for a scheduled appointment without notifying our office.

Medications

- Refills- Allow 2-3 business days for refills. Contact your pharmacy 5 days before running out of your medication and ask them to send us an electronic refill request, or you may send us a refill request through your patient portal.
- Physicians covering for PA's do not authorize refills on weekends.
- For your safety, you may be required to make an appointment in order to get a refill.

Controlled Substance prescriptions

- Must be picked up in person, and a photo ID must be presented
- No narcotics or controlled substances will be refilled on Fridays, Saturdays, Sundays or holidays.
- If family member will be picking up a prescription, the office must have that person's name in advance.
- The name of the person picking up prescriptions will be documented in the medical record.

Medications requiring prior authorizations- Note that some medications now require prior authorization from your insurance company, and we no longer issue prescriptions for those medications. Please contact your insurance company for medications that require prior authorization and let your provider know so they can recommend a suitable substitute. The increasing number of insurance plans and variations on formularies they dictate have forced us to set this policy. We apologize for any inconvenience.

Telemedicine

- The laws that protect privacy and confidentiality of personal medical information are also applied to telemedicine and information without your consent won't be disclosed
- A written record of your telemedicine visit will be kept in your medical record, not the actual video
- Although anticipated benefits may be expected from the use of telemedicine, no results can be guaranteed

Referrals

Any type of referral requires 5-7 business days. Referrals are the patient's responsibility and need to be requested prior to having the services rendered. Referrals will not be faxed – they must be picked up by the patient or mailed. Referrals will not be processed if patient is calling on the day of their appointment with specialist/testing. The patient will be expected to reschedule.

Please Note

We do submit claims under our insurance contracts with insurance companies. For all self-pay and non-contracted insurance, payment **must** be paid at time of service. Any balance after insurance payment **must** be paid in full within 30 days.

I understand and agree that it is my responsibility to know if my insurance has a deductible, copay, coinsurance, out-of-network benefits, usual and customary limit, prior authorization requirements, or any other type of benefit limitations for the services I receive. I agree to make any payment required during my visit in full. I understand that I am responsible for knowing what facilities are covered by my insurance which may include hospitals, labs, and testing facilities. I understand that I am responsible for knowing my benefits with my insurance, which may include coverage for any tests ordered.

Service Fees

- A \$30 service fee will be assessed for all returned checks.
- A \$75 service fee will apply to complete disability form from private agencies
- A 25% fee will be added to your balance if your account is sent to a collection agency and future payments will be on a cash basis.

Your insurance will be billed a "Late or Weekend Hours Visit Charge" if your appointment is 5pm or later on Saturday.

Cases of Divorce or Separation

The parent of legal guardian who brings the patient in for a visit will be responsible for copays and for any balances after insurance is filled.

Work Comp Visits

It is the patient's responsibility to provide ALL the insurance and business information if your visit is due to an injury sustained from a job or place of business. You must have this information released to the front desk prior to your scheduled appointment, and if you fail to provide the office with this information, you will need to pay for your visit or reschedule.

Auto Injuries & Accidents

If your visit is the result of an automobile accident/injury, note that we will only submit claims to your medical insurance that is in you chart. If you do not want this to occur, you must pay for your office visit, then you can submit this claim to the auto insurance policies. We do not submit claims to auto insurance plans. You may pay by check, charge, or debit card on the day of your visit.

Transfer of Medical Records

All transfer request must be on the request form. We will need 7-10 business days to process your request. There is a fee required to copy your chart. That fee is based off of a services fee dictated by Illinois state law, in addition to a charge per page fee. Your copies will be released once the final payment is received. Also, accounts must be paid in full before your copied record will be released.

Illinois Immunization Registry

By signing the agreement below, I agree to have my immunization record included in the Illinois Immunizations Registry. If you do not want your date available in the registry, please ask us and we will provide you with an opt-out of registry form to sign.

Assignment & Release

I hereby authorize that my insurance benefits be paid directly to Dr. Rife & Associates Family Medicine. I will be financially responsible for all non-covered services (copays, deductibles, cosmetic procedures, immunizations, etc.) I also authorize the practice to release any information required to process this claim to the insurance company or third-party payer.

- This release may be revoked at any time if written authorize is received stating the reason for such action
- Patients not in good financial standing with this practice may be dismissed (disengaged)
- HIPAA Rules are compiled within this office

Please acknowledge your acceptance of these terms by signing and dating the form below:

Patient Signature

Date

Relationship (if other than patient)

Patient Portal Authorization Form

This form must be completed to gain access to the online medical records of a patient, the patient portal. A new patient portal account will be established for those requesting access with the email address provided below.

I agree to the following:

- I must log in to Rife & Associates patient portal with my own user ID and password.
- I will abide by the terms and conditions of the Rife & Associates Patient Portal site.
- Rife & Associates has the right to revoke online access at any time.
- **I am 18 years old or over. If not, the legal guardian will complete all sections of this form.**

I understand that:

- For medical emergencies, dial 911. Rife & Associates patient portal is NOT to be used for urgent needs.
- All communication is sent to the practice, not directly to the provider. The message will be reviewed and responded to or forwarded appropriately.
- I will receive a Rife & Associates patient portal email notifying me when access is available with login credentials.

I understand that Rife & Associates patient portal is intended as a secure online source of confidential medical information. If I share my patient portal information username and password with another person, that person may be able to view my or my child's health information.

I agree that it is my responsibility to select a confidential password, to maintain my password securely, and to change my password if I believe it may have been compromised in any way.

I understand that my activities within Rife & Associates patient portal may be tracked by a computer audit and that entries I make will become part of the patient's medical record.

I understand that access to Rife & Associates patient portal is provided by Rife & Associates as a convenience to its patients and that they have the right to deactivate access to the portal at any time for any reason. I understand that the use of Rife & Associates patient portal is voluntary, and I am not required to use the patient portal.

Secure Email Address: _____

Patient Name (printed)

Date of Birth

Signature

Date

Complete section below if you are the legal guardian of patient.

Your Printed Name

Definition of Wellness Care, Illness Care, and Your Insurance (Non-Medicare)

It may seem like wellness and illness care are part of the same service, but routine health maintenance is different than treating an existing condition or a new illness. We recommend that patients schedule separate visits for wellness and illness (including medication refills). If you have concerns you want to have addressed, we prefer to see you for those concerns first, then reschedule the wellness visit. If you decide to discuss an illness condition at your wellness visit, or if we find an unexpected condition during the visit, we will charge an additional evaluation and management (E&M) code. This situation would be two visits, one illness and one wellness, and you will also be responsible for any copays or deductible amounts for the visits.

What is a wellness visit?

Wellness services are evaluations and advice to keep you well, including screening for such things as depression or diabetes, or for women, a pap smear, or a mammogram. We update your health history, allergies, family health history, diet, exercise, and substance use habits. We may offer immunizations, advice on improving your health habits, and how to prevent disease.

What is an illness visit?

An illness visit is for a new illness or for chronic conditions that have been diagnosed (diabetes, high blood pressure, or arthritis). There is added thought, work, and follow up involved: detailed questions, examinations, tests, referrals, therapy, advice, and prescriptions. An example would be diabetic care or blood pressure control where you often need to be seen on a regular basis.

Remember, insurance plans vary in terms of coverage, and can change over time. It is the patient's responsibility to understand his/her coverage. If you have any questions on our wellness/illness visit policy, please ask our staff before your visit.

I, _____, understand and agree to abide by this policy.

Patient Signature

Date

Financial Waiver Form

I understand that in the event that my health insurance, my Medicare insurance carrier, or work comp is not active or current, and/or they deny payment for any current or past visits, I will be responsible for any and all balances due on my account/my family's account.

This shall include, but is not limited to, any and all deductibles, co-pays, and/or services that are not covered under my plan. Payment will be submitted in full to the office immediately.

Patient Signature

Date

Relationship (if other than patient)



Medical History Form (Please complete all sections front and back)

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Occupation: _____ Height: _____ Weight: _____ Marital Status: S M D

Your Medical History

Please check below if you have had the following:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Depression | <input type="checkbox"/> Hay Fever/ Allergies | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Can't fall asleep |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Early Awakening |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Drowsy in daytime |
| <input type="checkbox"/> Breast problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> GI (stomach) problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> TB |
| <input type="checkbox"/> Chemical dependency | Date: _____ | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chest pain | Results: _____ | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Venereal Disease |

Other: _____

Medication and Dosages

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Allergy History

Please list all allergies (i.e. medications, foods, environmental, etc.) and write down your reaction.

Hospitalizations/ Surgeries

| Year | Hospital | Surgery or reason for hospitalization |
|-------|----------|---------------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Your Habits

Please check if appropriate

- | | | |
|-----------------------|--------------------|-----------------------|
| Smoking _____ | Caffeine _____ | Alcohol _____ |
| Packs per day: _____ | Daily intake _____ | If daily consumption: |
| Desire to quit: _____ | | _____ drinks per day |
| | | If monthly or less: |
| | | _____ per week |



Females (13 and over)

Please check below if you have had the following:

- Abnormal periods Breast lump Painful intercourse Vaginal discharge
 Abnormal bleeding Nipple discharge Pregnancy complications Other: _____

Age period started: _____ Last period: _____ Method of birth control: _____ No. of children: _____

| Last Pap | Results | Where | Last Mammogram | Results | Where |
|----------|---------|-------|----------------|---------|-------|
| | | | | | |

Males

Please check below if you have had the following:

- Erection difficulties Lump in testes Penis discharge Other: _____

Immunization history

| | Month | Year | Never |
|----------------------|-------|-------|-------|
| Last Tetanus Shot: | _____ | _____ | _____ |
| Last Pneumonia Shot: | _____ | _____ | _____ |
| Last Flu Shot: | _____ | _____ | _____ |

Where did you get your flu shot? _____ Do you get the flu shot each year? _____

Nutrition and Diet

How many times a week do you eat the following?

- Sweets/candy Soda Fried Foods Fish Caffeinated beverages
 Fast Foods Dairy Products Meat Bread/ cereal

Occupational History

Please check if appropriate

- Stress Heavy lifting
 Contact with bodily fluids Hazardous substances

Number of hours worked per week: _____

Depression screening

Please circle

- yes no During the past month have you often felt down, depressed, or hopeless?
 yes no During the past month have been bothered by having little interest or pleasure in doing things?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions I may have made in completing this form.

Patient Signature: _____ Date: _____

Physician Use only

| | Physical Activity | Alcohol | Smoking | Nutrition |
|--------------------------------------|-------------------|---------|---------|-----------|
| Patient advised on: | | | | |
| Patient given education material on: | | | | |

Physician Signature: _____ Date: _____

Patient Name _____

DOB _____

Date _____

Please fill in all boxes that apply

| Members | Year of Birth (if alive) | Alive? | Age at death (if deceased) | Healthy | Hypertension | Diabetes (What Type?) | Heart Disease (What Type?) | Stroke | Mental Illness (What Type?) | Cancer (Type? When diagnosed?) | Other | Unknown |
|----------------------|--------------------------|--------|----------------------------|---------|--------------|-----------------------|----------------------------|--------|-----------------------------|--------------------------------|-------|---------|
| Father | | Yes No | | | | | | | | | | |
| Mother | | Yes No | | | | | | | | | | |
| Brother 1 | | Yes No | | | | | | | | | | |
| Brother 2 | | Yes No | | | | | | | | | | |
| Sister 1 | | Yes No | | | | | | | | | | |
| Sister 2 | | Yes No | | | | | | | | | | |
| Grandfather Maternal | | Yes No | | | | | | | | | | |
| Grandmother Maternal | | Yes No | | | | | | | | | | |
| Grandfather Paternal | | Yes No | | | | | | | | | | |
| Grandmother Paternal | | Yes No | | | | | | | | | | |
| Son 1 | | Yes No | | | | | | | | | | |
| Son 2 | | Yes No | | | | | | | | | | |
| Daughter 1 | | Yes No | | | | | | | | | | |
| Daughter 2 | | Yes No | | | | | | | | | | |

Total Siblings _____ Brothers _____ Sisters _____ Healthy? _____ Total Children _____ Sons _____ Daughters _____ Healthy? _____

If you listed above any family member(s) with cancer, at what age were they diagnosed? _____ If deceased, what age at death? _____

Noncontributory if adopted Yes _____ No _____

Please fill out the reverse side if you have more than two brothers/ sisters/ sons or daughters with significant medical conditions.

Release for Medical Information

We will request medical records from information below.

Physician's Name

Address

City

State

Zip Code

Phone Number

Fax Number

I hereby authorize and request the release to:

Dr. Susan Rife Family Healthcare
10755 W. 163rd Place
Orland Park, IL 60467

Phone: 708-873-1187 Fax: 708-364-9307

Please release all documents from date _____ to _____ including:

_____ All Medical Care

_____ Laboratory Reports

_____ Radiology Reports

_____ Other

Patient's Name _____

DOB _____

Patient's Signature _____

Date _____

Patient's Address _____

Signature of Witness _____