NEW PATIENT PROCESSING

Please send the following items with the completed paperwork.

___Copy of Driver's License or other government photo ID

___Copy of Insurance Card (primary, secondary and tertiary)

___ List of all medications, including dosage

___ Power of Attorney

Please complete these attached forms and return them to our office by
Fax: 817-731-1291 or Email: **RPMC@riverparkmedicalclinic.com**

___PATIENT DATA FORM **(page 1)**

___FINANCIAL RESPONSIBILITY **(page 2)**

___MEDICAL RECORDS RELEASE **(page 3)**

___PATIENT CARE COMMUNICATION **(page 4)**

___ PRESCRIPTION HISTORY CONSENT **(page 5)**

___REVIEW OF POLICIES **(page 6)**

___CONSENT TO E-MAIL AND/OR TEXT MESSAGE **(page7)**

___ ASSISTED LIVING AUTHORIZATION **(page 8)**

If you have questions regarding new patient processing, please call River Park Medical Clinic at 817-731-1289.

We look forward to meeting you.

Visit our web site at www.riverparkmedicalclinic.com for more information.

PATIENT DATA FORM- River Park Medical Clinic

Patient Information

Patient Last Name	Middle Initial
Patient First Name	Date Of Birth
Facility Address or Name of Facility	Room No.
City	
State	Zip
Home Phone #	Cell Phone #
Work Phone #	Work Phone Extension

Sex □ Male □ Female
Marital Status □ Single □ Divorced □ Married □ Widowed
Social Security
Employer Name
Occupation
Patient's Email Address

Emergency Contact Information

Emergency Contact Name	
Emergency Contact Home Phone #	Emergency Contact Cell/Work Phone #
Relationship to Patient	

Patient's Race	
□ American Indian/Alaska Native	□ Black/African American
□ Asian	□ Prefer to not answer
□ White	□ Native Hawaiian/Pacific Islander
□ Hispanic	
□ Other	
Ethnicity □ Hispanic/Latino □Prefer to not answer □ Non Hispanic/Latino	
Preferred Language	

Is the patient responsible for payments on this account? ___NO ___YES
If NO, Please fill out the responsible party information below.

Responsible Party Last Name	Date Of Birth
Responsible Party First Name	Sex □ Male □ Female
Responsible Pary Address	
City	
State	Zip

Responsible Party Home Phone
Responsible Party Cell Phone
Relationship to Patient
If the responsible party is not the spouse or parent to a minor patient, then POA paperwork must be provided. If the responsible party is not the spouse, parent, or POA, please complete **Patient Care Communication Form.**

Appointment Contact

Who should we contact for appointments?	Preferred Phone #	Can we text to this #? □ YES □ NO

Pharmacy Information

Name of Preferred Pharmacy	Address of Preferred Pharmacy	Pharmacy Phone #

X_____ **Date** _____

Signature of Patient or Patient's Personal Representative

_____

If you are the Patient's Personal Representative, what is your relationship to the patient?

FINANCIAL RESPONSIBILITY
River Park Medical Clinic

If you do not have insurance, payment for services are due at the time of service.

If you have insurance, we encourage you to become familiar with your plan and your insurance benefits prior to receiving medical service.

Services rendered and not covered by insurance will be your responsibility.

All deductibles and co-pays will be collected at the time of service.

Do you have Medical Insurance? ___YES ___NO
If YES, please fill out your insurance information below.

***NAME of PRIMARY INSURANCE COMPANY**	***NAME of EMPLOYER**		**PATIENT RELATIONSHIP TO SUBSCRIBER**
***LAST NAME, FIRST NAME, MIDDLE INITIAL of SUBSCRIBER**			_____Self _____Spouse _____Child
***SOCIAL SECURITY # of SUBSCRIBER**	**DATE of BIRTH of SUBSCRIBER**	**SEX of SUBSCRIBER**	
***POLICY # or MEMBER # or SUSCRIBER # / GROUP NUMBER**			

***NAME of SECONDARY INSURANCE COMPANY**	***NAME of EMPLOYER**		**PATIENT RELATIONSHIP TO SUBSCRIBER**
***LAST NAME, FIRST NAME, MIDDLE INITIAL of SUBSCRIBER**			_____Self _____Spouse _____Child
***SOCIAL SECURITY # of SUBSCRIBER**	**DATE of BIRTH of SUBSCRIBER**	**SEX of SUBSCRIBER**	
***POLICY # or MEMBER # or SUBSCRIBER # / GROUP NUMBER**			

_____ _____
Patient Name (print) **Date of Birth**

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____
If you are the **Patient's Personal Representative**, what is your relationship to the patient?

MEDICAL RECORDS RELEASE
River Park Medical Clinic

By signing this form, I authorize River Park Medical Clinic to receive confidential health information about me. I authorize release of a copy of my medical records, or a summary or narrative of my protected health information to:

River Park Medical Clinic
2550 River Park Plaza, Suite 110
Fort Worth, TX 76116

FAX: 817-731-1291 PHONE: 817-731-1289

The purposes for this release of information is to transfer my medical records, summary or narrative of my protected health information to Dr. Quang Le.

_____ _____
Patient Name (print) **Date of Birth**

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____
If you are the **Patient's Personal Representative**, what is your relationship to the patient?

PATIENT CARE COMMUNICATION
River Park Medical Clinic

Please list the names of any person(s), if any, whom we may inform or communicate with about your medical information, diagnosis and financial information as related to your balance. They must be listed on this form. For any future changes to this information, please notify us in writing.

Name: _____ DOB: _____

Relationship to patient: _____

Phone #_____

Name: _____ DOB: _____

Relationship to patient: _____

Phone #_____

Name: _____ DOB: _____

Relationship to patient: _____

Phone #_____

Name: _____ DOB: _____

Relationship to patient: _____

Phone #_____

Name: _____ DOB: _____

Relationship to patient: _____

Phone #_____

_____ _____

Patient Name (print) **Date of Birth**

_____ _____

Signature of Patient or Patient's Personal Representative **Date**

_____

If you are the **Patient's Personal Representative**, what is your relationship to the patient?

PRESCRIPTION HISTORY CONSENT
River Park Medical Clinic

I authorize River Park Medical Clinic and it's providers to view my external prescription history. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by providers and staff at River Park Medical Clinic and that it may include prescription back in time for several years. I understand this will allow my providers to better coordinate my care and medication history to maximize the effectiveness and safety of my treatment plan.

_____ _____

Patient Name (print) **Date of Birth**

_____ _____

Signature of Patient or Patient's Personal Representative **Date**

_____

If you are the **Patient's Personal Representative**, what is your relationship to the patient?

REVIEW OF POLICIES
River Park Medical Clinic

Review of *Notice of Privacy Practices*

I have reviewed River Park Medical Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

Review of *Notice of Patient Rights and Responsibilities*

I have reviewed River Park Medical Clinic's Notice of Patient Rights and Responsibilities, which is meant to inform me of my rights and responsibilities while undergoing medical care. I understand that I am entitled to receive a copy of this document at my request.

Review of *Assignment of Benefits*

I have reviewed the Patient Financial Policy Sheet, which outlines River Park Medical Clinic's financial policies. I understand that I am entitled to receive a copy of this document at my request.

Review of *Patient Financial Policy*

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time. I understand that I am entitled to receive a copy of this document at my request.

I agree to the policies and terms outlined in the forms listed above, which include:

1. ***Notice of Privacy Practice***
2. ***Notice of Patient Rights and Responsibilities***
3. ***Assignment of Benefits***
4. ***Patient Financial Policy***

I hereby authorize River Park Medical Clinic to furnish information to my insurance carriers regarding diagnosis and treatment. I understand that I am responsible for payment of the services rendered. I also authorize payment to be made directly to my physician by my insurance company. A photocopy of this authorization shall be considered as valid as the original.

_____
Patient Address (please fill out even if you have given us this information previously)

_____
City **State** **Zip**

_____ _____
Home Phone **Work Phone**

_____ _____
Patient Name (print) **Date of Birth**

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____
If you are the **Patient's Personal Representative**, what is your relationship to the patient?

Communication Preferences
River Park Medical Clinic

TELEPHONE CALLS and VOICE MESSAGES

Please provide us with the phone number that you prefer to be used when our office is calling to leave you messages.

Phone #: (_____)-_____-_____

Is this a cell phone or a home phone number? _____

A phone number must be provided

TELEPHONE TEXTING

We have the ability to text you and to provide general health reminders and information, such as notifying you that your lab results are normal.

The cell phone number that I authorize to receive text messages is:

Cell Phone: (_____)-_____-_____

(Leave the cell phone # blank if you do not want to receive text messages)

E-MAIL / PATIENT PORTAL ACCESS

We have the ability to e-mail you and to provide general health reminders and information. The e-mail you provide will also be used for access to our online patient portal.

The email that I authorize to be used is:

E-mail: _____

If an e-mail is not provided, you will not have access to the patient portal.

I understand that this request to receive emails and/or text messages will be in effect unless I request a change in writing.

_____ _____

Patient Name (print) **Date of Birth**

_____ _____

Signature of Patient or Patient's Personal Representative **Date**

_____

If you are the **Patient's Personal Representative**, what is your relationship to the patient?

ASSISTED LIVING
Authorization Form for Release of Protected Health Information
River Park Medical Clinic

Authorization for Release of Protected Health Information to the Assisted Living Facility:
By signing this form, I authorize River Park Medical Clinic to release confidential health information, medical records, or a summary or narrative of my protected health information to the employees/staff at _____ Room No._____ (name of Assisted Living Facility and room number).

***Please Circle One: MEMORY CARE ASSISTED LIVING Move in date: _____**

Authorization for Release of Protected Health Information to Primary Contact:
The providers at River Park Medical Clinic will need to reach out to the POA and family to discuss medical updates regarding assisted living patients. Please provide us with the preferred primary contact. Please provide us with any POA paperwork that you have regarding this contact.

Primary Contact Name: _____ DOB: _____

Relationship to patient: _____

Phone #_____ Email Address: _____

Additional contacts may be added to the **PATIENT CARE COMMUNICATION FORM.**

Authorization for Release of Protected Health Information to Financial Party:
A statement of balance due will be mailed after processing medical claims with the insurance company(s). Please provide the mailing information for these statements.

Name of person to received balance statements: _____

Relationship to patient: _____ Phone #_____

Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

~Quang Le, DO ~2550 River Park Plaza, Suite 110 ~817-731-1289(phone)
~ Fort Worth TX, 76116 ~817-731-1291(fax)

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

_____ _____
Patient Name (print) **Date of Birth**

_____ _____
Signature of Patient or Patient's Personal Representative **Date**

_____
If you are the **Patient's Personal Representative**, what is your relationship to the patient?