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
Email (PREFERED): RPMC@riverparkmedicalclinic.com or **Fax: 817-731-1291**

___ **Patient Data Form** (page 1)

___ **Consent Form for the following**: (page 2)
Financial Responsibility
Prescription History
Review of Policies
Assisted Living Authorization Form for Release of Protected Health info
Authorization for Release of Protected Health Information to Primary Contact:
Authorization for Release of Protected Health Information to Financial Party
Patient Care Communication

____ **MEDICAL RECORDS RELEASE** (Please fill out if you want us to retrieve records from your previous doctor. (page 3)

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 (Please send copy of DL or other government photo ID)

Patient Full Name:	**Date Of Birth:**
Social Security:	**Marital Status** □ Single □ Divorced □ Married □ Widowed **Sex:** □ Male □ Female
Patient's Race: □ American Indian/Alaska Native □ Asian □ White □ Hispanic □ Other □ Black/African American □ Native Hawaiian/Pacific Islander □ Prefer to not answer **Ethnicity:** □ Hispanic/Latino □Prefer to not answer □ Non Hispanic/Latino **Preferred Language:**	
Facility Name & Address:	**Room No.**
Please Circle One: MEMORY CARE ASSISTED LIVING Move in date: _____	

Home Phone #	**Cell Phone #**	**Patient's Email Address:**

Is the patient responsible for payments on this account? ___NO ___YES
If NO, Please fill out ****Authorization for Release of Protected Health Information to Financial Party** on page 2 at the bottom.

EMERGENCY CONTACT INFORMATION (Is this the POA? □Yes or □No) If yes, please send copy of POA

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

INSURANCE INFORMATION (please send copy of primary and secondary insurance card)

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

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

PHARMACY INFORMATION

Name of Preferred Pharmacy	Address of Preferred Pharmacy	Pharmacy Phone #

FINANCIAL RESPONSIBILITY

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.

PRESCRIPTION HISTORY CONSENT

I authorize River Park Medical Clinic and its 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.

REVIEW OF POLICIES

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.

ASSISTED LIVING

Authorization Form for Release of Protected Health Information

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

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.

Additional contacts may be added below:

- ****PATIENT CARE COMMUNICATION FORM**

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.

Contact #1 Full Name: _____ DOB: _____ Relationship to patient:_____

Phone #_____

Contact #2 Full Name: _____ DOB: _____ Relationship to patient:_____

Phone #_____

- ****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 Full Name (PRINT) **Date of Birth**

_____ _____ _____
Signature of Patient or Patient's Personal Representative **Relationship to the patient** **Today's Date**

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 Full Name (PRINT) **Date of Birth**

_____ _____ _____
Signature of Patient or Patient's Personal Representative **Relationship to the patient** **Today's Date**