As a Federally Qualified Health Center, River Valley Primary Care Services is required to collect demographic information regarding the patients we serve. The information you provide is confidential.

Section 1: Patient Information

First Name: _____ **Middle Name:** _____ **Last Name**: _____

Social Security Number: _____ **Sex**: ☐ Male ☐ Female **Date of Birth**: _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code**: _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work _____

Preferred Communication: ☐ No Preference ☐ Phone ☐Mail ☐MyChart (If MyChart, please provide an email)

Email Address:_____ **Marital Status**: ☐ Single ☐ Married ☐ Other: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____ Interpreter Needed: ☐ Yes ☐ No

Ethnic Origin (Please check one): ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Race: (Please check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Not Reported/ Refused ☐ Other: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female) ☐ Not Reported/Refused ☐ Transgender Male (Female-to-Male) ☐ Non-Binary (Identifying as any other gender than female or male)☐ Uncertain ☐ Other _____

Sexual Orientation: ☐ Heterosexual/Straight ☐ Homosexual/Gay/Lesbian ☐ Bisexual ☐ Uncertain ☐ Other ☐ Not Reported/Refused

Employer: _____ **Address:**_____ **Phone:**_____

Employment Status: ☐ Full Time ☐ Part-Time ☐ Self ☐ Retired ☐ Not Employed

Homeless Status: ☐ Not Homeless ☐ Homeless shelter ☐ Transitional ☐ Doubling Up ☐ Street ☐ Other _____

Worker Status: ☐ Migrant ☐ Not Migrant ☐ Seasonal **Veteran:** ☐ Yes ☐ No

Special Needs? ☐ None ☐ Glasses ☐ Hearing Aids ☐ Other _____ ☐ Patient Refused Disabled**?** ☐ Y ☐ N

1. **Pharmacy Name:** _____ **City**: _____ **Mail Order:** ☐ Y ☐ N
2. **Pharmacy Name:** _____ **City**: _____ **Mail Order:** ☐ Y ☐ N

*RVPCS is a federally funded organization and therefore is required to ask our patients their sexual orientation as well as their gender identity in order to identify and reduce health disparities as well as promote culturally competent care. If you do not wish to disclose this information, please mark "Not Reported/Refused"

Section 2: Guarantor (Finically Responsible Party) Information

Guarantor is: ☐ Patient (no need to complete the rest of this section) ☐ Person ☐ Company

Patient's relationship to Guarantor: ☐ Child ☐ Parent ☐ Spouse ☐ Employer ☐ Other: _____

First Name: _____ **Middle Name:** _____ **Last Name**: _____

Social Security Number: _____ **Sex**: ☐ Male ☐ Female **Date of Birth**: _____

Mailing Address: _____ **City:** _____

State: _____ **Zip Code**: _____ **Primary Phone:** ☐ Home ☐ Cell ☐ Work

Section 3: Household and Income Information

RVPCS is a federally funded organization and therefore is required to ask our patients about their family income for reporting.
If you are in need of financial assistance, please ask for our Sliding Fee Application.
Please indicate your family annual income (required information for federal reporting)

How many persons are in the household? _____

____$0-$5,000 ____$5,000-$10,000 ____$10,000-$20,000 ____$20,000-$30,000 ____$30,000-$40,000

____$40,000-$50,000 ____$50,000-$60,000 ____$60,000-$70,000 ____$70,000-$80,000 ____$80,000-$90,000

____$90,000+ ____ Do not wish to Disclose/Unknown

Section 4: Insurance Information

Please provide your Insurance card(s), insurance name, policy number, and subscriber's info if different from patient.

Primary Insurance Name and Policy Number: _____

Secondary Insurance Name and Policy Number: _____

Subscriber Information (*If Different from patient or guarantor*):

First Name: _____ **Middle Name:** _____ **Last Name**: _____

Social Security Number: _____ **Sex**: ☐ Male ☐ Female **Date of Birth**: _____

Section 5: Emergency Contact & HIPAA Information

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

Name:_____Relationship_____Phone_____**Authorized HIPAA:** ☐ Yes ☐ No

I give River Valley Primary Care Services permission to discuss protected health information and to release test results to the following person(s) named above as Authorized HIPAA.

Section 6: Consent to Treatment and Payment Authorization

You are responsible for your own bill.*

As a courtesy, RVPCS will submit charges to your insurance carrier.

Understand that you are financially responsible for all charges incurred whether or not you have insurance.

CONSENT FOR TREATMENT AT RIVER VALLEY PRIMARY CARE:

1. I am aware that the practice of medicine is not an exact science and that the health center offers no guarantees concerning any treatments or examinations I may have here.
2. I authorize the Health Center and its employees to use the information contained in my record for proper medical purposes, and for clinical improvement audits with information that would be de-identified.
3. I authorize the medical staff of the Health Center to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess, diagnose and treat the condition for which I am seeking care. I understand that it is the responsibility of the provider to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options.
4. I understand that the services offered at River Valley Primary Care include medical care, mental health, behavioral health, nutrition, and dental care.
5. I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by the provider.

PAYMENT OF BENEFITS AND INFORMATION RELEASE: I request that payment of authorized insurance benefits be made on my behalf to the Health Center for any services furnished to me by the Health Center. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered by the Health Center.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received or been offered a copy of River Valley Primary Care's Notice of Privacy Practices.

SIGNATURE: By signing below, I acknowledge that I have read all the above information, that I understand and agree to the above statements, and that I have been afforded the opportunity to have any questions I might have addressed.

As the parent/guardian for the identified patient, I am consenting for _____ _____, to receive treatment at any RVPCS location.
Name of child / minor Date of Birth

_____ _____
Patient/Guardian Signature Date

* ☐ *Please check if patient is incarcerated. Must sign above for consent to treat.*