RVPCS Patient Registration Form

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**:_____

Suffix: _____ **Social Security Number**: _____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Marital Status**: ☐ Single ☐ Married ☐ Other: _____

Mailing Address: _____ **City:** _____

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

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

Place of Birth: _____ **Mother's Maiden Name:**_____

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

Student Status: ☐ Full Time ☐ Part-Time ☐ Not in school

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

How did you learn about RVPCS? ☐ Friend/Family ☐ Online ☐ Advertisement ☐ Other _____

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Translator: _____☐ Other: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Not Reported/ Refused ☐ Other: _____

Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Hispanic ☐ Not Reported/Refused

Gender Identity: ☐ Not Reported/Refused ☐ Female ☐ Male ☐ Transgender Female (Male-to-Female)

☐ Transgender Male (Female-to-Male) ☐ Non-Binary (Identifying as any other gender than female or male)

☐ Uncertain ☐ Other: _____

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

☐ Bisexual ☐ Uncertain ☐ Other: _____

Section 2: Guarantor (Financially Responsible Individual) 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**:_____

Suffix: _____ **Social Security Number**:_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Marital Status**: ☐ Single ☐ Married ☐ Other: _____

Street Address: _____ **City:** _____

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

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

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other: _____

Section 3: Family Income and Shelter Information

We request income on all patients for governmental reporting purposes.
If eligible for the Sliding fee Scale, please complete the separate Sliding Fee Application

Income Period: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually ☐ Other: _____

Gross Income for Period: $_____ **Number of Individuals Income Supports:**_____ **Disabled:** ☐ Yes ☐ No

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

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

Section 4: Patient Insurance Information

Please allow our staff to copy your insurance card(s)

Primary Insurance Information

Insurance Company/Plan Name: _____

Member ID:_____ **Group Number:** _____

☐ **Use Patient Information** (No need to complete the rest of this section)

Patient's Relation to Holder: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

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

Suffix: _____ **Social Security Number**:_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code**: _____ **Phone:** _____

Secondary Insurance Information

Insurance Company/Plan Name: _____

Member ID:_____ **Group Number:** _____

☐ **Use Patient Information** (No need to complete the rest of this section)

Patient's Relation to Holder: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

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

Suffix: _____ **Social Security Number**:_____ **Sex**: ☐ Male ☐ Female

Date of Birth: _____ **Street Address:** _____

City: _____ **State:** _____ **Zip Code**: _____ **Phone:** _____

Section 5: Emergency Contact Information

Patient's relation to emergency contact: ☐ Child ☐ Parent ☐ Spouse ☐ Other: _____

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

Street Address: _____ **City:** _____

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

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

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.

- I hereby assign, transfer, and set over to RVPCS all of my rights, title, and interest to my medical reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I, revoking said authorization, give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

- I authorize consent to outpatient care which may encompass examination and medical or dental treatment, routine diagnostic procedures including [but not limited to] laboratory studies, dental x-rays, electrocardiogram [EKG], and administration of medications as ordered by the physician or dentist. [Dental treatment at Ratcliff only.]

- I further authorize the release of pertinent medical and treatment documentation to other physicians involved in by care through referral or shared care.

- I, the undersigned, understand that a **PHOTOGRAPH** is included as a part of my electronic health record. I relieve River Valley Primary Care Services, Inc. of any use of my photograph for treatment, identification, or education purposes acknowledging that uses for any other purposes must be specifically obtained from me.

- I authorize treatment for my identified minor or myself. I also understand that examination and treatment may be by the medical or dental staff defined as Medical Doctor, Doctor of Dentistry, Dental Hygienist, Advanced Practice Nurse, or Physician Assistant. Others services may be rendered by their clinical assistants by direct order of the medical or dental staff. I also understand that examination and treatment may be by a student under the supervision of a clinician or dentist.

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

_____ _____

Patient/Guardian Signature Date

Section 7: HIPAA / Notice of Privacy / Patient Consent to Share Information

Please provide the following information to insure clear communication concerning your protected health information is maintained:

PATIENT NAME: _____ **DOB**: _____

Preferred method of confidential communication [rank in order of preference]:

____ Home Phone ____ Postal Mail

____ Cell Phone ____ Email

____ Work Phone ____ Other: _____

May we leave a message for you/the patient about their healthcare? ☐ *Yes* ☐ *No*

RVPCS utilizes the Patient Portal. This allows you/the patient access to electronically communicate with your care team via the patient portal. You can request your records, results, refills, and ask questions. All communication through the portal is secure and part of your medical record.

Are you interested in using the patient portal? ☐ Yes ☐ No

I [the patient/guardian] authorize RVPCS to share my personal health information with the named persons below. Each named persons have my permission to obtain or discuss healthcare information contained in my medical / dental record.

If signing this for a child/minor – please include the guardian(s) or responsible party for the patient.

Name:_____ Relationship_____ Phone #_____

Name:_____ Relationship_____ Phone #_____

Name: _____Relationship_____ Phone #_____

_____ _____

Patient/Guardian Signature Date

The above signature acknowledges that I have been given, read, and understand the Notice of Privacy Practices of River Valley Primary Care Services.

River Valley Primary Care Services, Inc. 9755 W. State Highway 22 Ratcliff, AR 72951 Phone: (479) 635-5300

River Valley Primary Care Services - Dental Office 9755 W. State Highway 22 Ratcliff, AR 72951 Phone: (479) 635-0178

RVPCS - Northside Clinic 4900 Kelley Highway Fort Smith, AR 72904 Phone: (479) 785-5700

Northside Clinic at 6th Street 3202 North 6th Street Fort Smith, AR 72904 Phone: (479) 783-3900

Mulberry Family Clinic 437 North Main Street Mulberry, AR 72947 Phone: (479) 997-1484

Mountainburg Family Clinic 4 Highway 71 N.E. Mountainburg, AR 72946 Phone: (479) 369-2091

Barling Family Clinic 815 Fort Street, Suite B Barling, AR 72923 Phone: (479) 434-4747

Lamar School Based Health Center 635 Childers Street Lamar, AR 72846 Phone: (479) 885-3966