



Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

**GENERAL CONSENT TO MEDICAL TREATMENT**

I request and authorize Riverview Medical Group, their physicians, their associates and assistants (hereinafter "Physician(s)") who may attend to me and/or my dependent(s) during any visit, to perform routine medical tests and procedures and to provide drugs, medical care and other services as prescribed for me and/or my dependent(s) health and well-being. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me by Riverview Medical Group or Physicians, nor have I relied upon any such representations, warranties, or guarantees.

\_\_\_\_\_ Initials and Date

**MISSED APPOINTMENTS**

I hereby agree to be responsible for a charge of \$25.00, which may be assessed by Riverview Medical Group for appointments missed or cancelled with less than 24 hours notice. I understand these charges will not be submitted to my insurance.

\_\_\_\_\_ Initials and Date

**RESPONSIBLE PARTY INFORMATION (Person signing form to accept financial responsibility)**

RESPONSIBLE PARTY NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ (If different from patient)

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PRIMARY PHONE: ( ) \_\_\_\_\_ SECONDARY PHONE: ( ) \_\_\_\_\_  
Circle One: Home - Cell - Work Circle One: Home - Cell - Work

**FINANCIAL AGREEMENT/CONSENT TO FILE INSURANCE**

I hereby agree to be responsible for charges covering all services rendered by Riverview Medical Group. I shall also be responsible for any legal and/or attorney fees required to collect for these services, to which interest may be added at the current legal rate. I hereby assign directly to Riverview Medical Group and Physicians payment of my health insurance benefits applicable to these services and authorize the collection of such funds on my behalf. Such payments shall not exceed my balance owed to Riverview Medical Group. I acknowledge and understand that I and any guarantor signing on my behalf are personally responsible for all charges not otherwise paid by assignment to insurance benefits. I also certify that any information which I have given in applying for coverage under the Social Security Act, or any insurance or other information, which I have provided, is true and correct. If I provide Riverview Medical Group or its agents with my cell phone number, I authorize Riverview Medical Group or its agents to call my cell phone either manually or by auto-dialer in order to collect any amounts I owe. I understand that any e-mail I provide is my personal e-mail and I authorize Riverview Medical Group or its agents to contact me via that e-mail address.

**SIGNATURE OF RESPONSIBLE PARTY (18 years or older)**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_ STAFF INITIALS: \_\_\_\_\_



Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_

**COMMUNICATION OF PRIVATE HEALTH INFORMATION AUTHORIZATION**

Please  and fill out all that are acceptable forms of communication to provide quality patient care.

- I authorize the staff of Riverview Medical Group to leave a message regarding my Private Health Information on my home voicemail or answering machine.
- I authorize the staff of Riverview Medical Group to leave a message regarding my Private Health Information on my cell phone voicemail.
- I authorize the staff of Riverview Medical Group to leave a message regarding my Private Health Information on my work voicemail or answering machine.
- I authorize the staff of Riverview Medical Group to mail written communication to my home address.
- I authorize the staff of Riverview Medical Group to speak with the following individuals to discuss Medical and/or Financial information.

**Medical:**

Name	Phone Number	Relationship to Patient
------	--------------	-------------------------

Name	Phone Number	Relationship to Patient
------	--------------	-------------------------

**Financial:**

Name	Phone Number	Relationship to Patient
------	--------------	-------------------------

Name	Phone Number	Relationship to Patient
------	--------------	-------------------------

**Emergency Contact: (Please list one individual not living at the same address)**

Name	Phone Number	Relationship to Patient
------	--------------	-------------------------

Name	Phone Number	Relationship to Patient
------	--------------	-------------------------

All information signed and authorized by me on this form shall remain in effect until my written revocation.

\_\_\_\_\_ Initial/Date

**HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT**

By initialing below, I acknowledge that I have been advised of the Notice of Privacy Practices of Riverview Health and may obtain a written copy upon request or via the website at [www.riverview.org](http://www.riverview.org).

\_\_\_\_\_ Initial/Date

Patient or Legal Guardian's signature if patient is a minor	Date
---	------

**\*\*\*STAFF USE ONLY\*\*\***

Riverview Medical Group personnel witnessing form completion. \_\_\_\_\_

Date: \_\_\_\_\_