VIBRANT HEALTH FAMILY CLINICS

PATIENT INFORMATION

Account # *(IF UW-RF STUDENT, INDICATE LOCAL ADDRESS HERE)*

Last First Middle Maiden	Date of Birth MO_______ DAY_______ YR_______	Social Security #
Address	Home Phone #	Sex M______ F______
	Email Address*	
Employer Name / Address / Phone	Cell Phone #	
Marital Status S M W D	Patient Employment Status (check one) ☐ FT Student ☐ PT Student ☐ Retired ☐ FT ☐ PT ☐ Self Employed ☐ Unemployed	

DEMOGRAPHICS

Language (check one) ☐ English ☐ Spanish ☐ Hmong ☐ Sign Language ☐ Unknown/Declined ☐ Other: ________________

Race (check one) ☐ Caucasian ☐ African American ☐ Native American ☐ Asian ☐ Declined ☐ Unknown

Ethnicity (check one) ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Declined

UW-RF STUDENT ☐ **Yes** ☐ **No**

BILL SENT TO:
☐ **Local Address**
☐ **Permanent Address**

RESPONSIBLE PARTY (if different from above)

Account # **(IF UW-RF STUDENT, INDICATE PERMANENT ADDRESS HERE)**

Last First Middle Maiden		Date of Birth MO_______ DAY_______ YR_______	Social Security #
Relationship to Patient ____ Spouse ____ Parent ____ Other	Marital Status S M W D	Employment Status (check one) ☐ Retired ☐ FT ☐ PT ☐ Self Employed ☐ Unemployed ☐ FT Student ☐ PT Student	
Address		Home Phone #	Sex M______ F______
		Cell Phone #	
Employer Name / Address		Telephone #	

INSURANCE COMPANY NAME

Subscriber Name	Date of Birth	ID #	Group #
Emergency Contact Name (outside of home)		Relationship	Phone #
Name and DOB of Immediate Family Members seen at RFMC/EMC/SVMC			

CONSENT

I understand that I/my dependents have a health problem, which requires diagnosis and/or treatment. I voluntarily consent to such diagnostic procedures and medical care ordered by my physician, which in his/her opinion are necessary to treat my health problem. I further consent to follow-up care as may be ordered by the physician. No guarantees have been made to me as to the results of examinations or treatments provided.

I understand that I may review and copy my medical record at my own expense and that this review shall take place in accordance with clinic policy. At no time will this consent allow Vibrant Health Family Clinic to give information to other persons or parties. I understand that I may authorize other persons to review and copy my medical record by signing a statement which identifies the person, purpose of the disclosure, type of information to be disclosed and the time period during which disclosure is permitted.

_____________________________ Dated

_____________________________ Signature

_____________________________ Printed Name

VIBRANT HEALTH FAMILY CLINICS
BILLING POLICY AND AUTHORIZATION

Initial

ASSIGNMENT OF BENEFITS

_________ I authorize payment of medical benefits to the Vibrant Health Family Clinics for services rendered to myself and/or my dependents. I agree to accept responsibility for any deductible, coinsurance, non-covered services, investigative services, those which my insurance company may deem as not medically necessary or, if I have not designated the Vibrant Health Family Clinics as my primary care clinic with my HMO.

RECORD RELEASE

_________ I hereby authorize the release of any information, including medical and billing information, by Vibrant Health Family Clinics, to other health care providers and facilities who are involved in my treatment and/or insurance company. I further authorize Vibrant Health Family Clinics to retrieve my external medication history and release information for prior authorization of my medications.

MEDICARE AUTHORIZATION

_________ I request that payment of authorized Medicare benefits be made on my behalf to the Vibrant Health Family Clinics for services furnished to me by the clinic providers. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

REFUNDS

_________ Refunds will not automatically be refunded if the amount is under $10.00, unless stated by law. The amount will remain on the account to apply to future services. You may request a refund by calling the Business Office at 715-425-6701.

_________ I understand and agree that my insurance company may share my past, current and future health and account records with Vibrant Health Family Clinics about services I have received from Vibrant Health Family Clinics and other care providers unrelated to Vibrant Health Family Clinics. These records may be used by Vibrant Health Family Clinics as needed to manage or coordinate my care and to improve the quality of that care.
If I do not agree to this, I will initial here _______ meaning insurance company may not release any identifiable health information from providers unrelated to Vibrant Health Family Clinics for purposes described above.

Is Vibrant Health Family Clinics (River Falls, Spring Valley, or Ellsworth) your primary clinic/healthcare home?

☐ **Yes** ☐ **No**

If yes, who is your primary Health Care Provider?______________________________

____ ______________________________________
Signature Date Print Name

Patient Name:_________________________________ Employer:______________________________

Email Address:____ (Office Use) MRN #_______________

(email addresses used only for non-confidential clinic business correspondence)