VIBRANT HEALTH FAMILY CLINICS
BILLING POLICY AND AUTHORIZATION

ASSIGNMENT OF BENEFITS

Initial

_____ 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 data sources such as health care providers and facilities that provided medical care and or my insurance company. I further authorize Vibrant Health Family Clinics to retrieve my external medication history, immunization 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.

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

☐ Yes ☐ No

If yes, which of our providers is your primary? _____

Signature _____ Print Name _____ Date _____

Patient Name if minor: _____ Employer: _____

Patient's Email Address: _____

AUTHORIZATION FOR APPOINTMENT REMINDERS: By selecting an appointment reminder type below you are authorizing VHFC to send automated appointment reminders.

Appointment Reminder Methods (Select only 1)

☐ Telephone Call Telephone Number _____

☐ Text Message Telephone Number _____

☐ E-mail Email Address _____

(Office Use) MRN# _____

VIBRANT HEALTH FAMILY CLINICS

PATIENT INFORMATION

MRN #

Last	First	Middle	Maiden	Date of Birth MO_____ DAY_____ YR_____
Address			Home Phone #	Sex M_____ F_____
			Email Address*	
UWRF Student ☐ Yes ☐ No	CVTC Student ☐ Yes ☐ No		Cell Phone #	
Marital Status S M W D	Spouse's Name	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 ☐ Other: _____
☐ Declined ☐ Unknown

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

RESPONSIBLE PARTY (if different from above) **(IF STUDENT, INDICATE PERMANENT ADDRESS HERE)**				Employer Name & Phone #
Last	First	Middle	Maiden	Date of Birth MO_____ DAY_____ YR_____
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 #	
Emergency Contact Name (outside of home)			Relationship	Phone #

INSURANCE COMPANY NAME

Subscriber Name	Date of Birth
Name and DOB of Immediate Family Members seen at River Falls, Ellsworth, Spring Valley	

CONSENT

By signing below, I voluntarily agree to the following provisions of this form: **Consent to Treatment**

I allow Vibrant health Family Clinics to provide health care services to me that may be deemed to be routine or otherwise necessary. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic, radiology and laboratory procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

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. 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