

## River Falls / Ellsworth / Spring Valley Medical 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				Telephone #	Sex M _____ F _____
				Driver's License	
Employer Name / Address				Telephone #	
Marital Status S   M   W   D		Patient Employment Status (check one) <input type="checkbox"/> FT Student <input type="checkbox"/> PT Student <input type="checkbox"/> Retired <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed			UW-RF STUDENT <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>RESPONSIBLE PARTY (if different from above)</b>				<b>(IF UW-RF STUDENT, INDICATE PERMANENT ADDRESS HERE)</b>	
<b>Account #</b>				<b>BILL SENT TO:</b> <input type="checkbox"/> Local Address <input type="checkbox"/> Permanent Address	
Last	First	Middle	Maiden	Date of Birth MO _____ DAY _____ YR _____	Social Security #
Relationship to Patient   ___ Mother   ___ Father   ___ Other			Marital Status S   M   W   D	Employment Status (check one) <input type="checkbox"/> Retired <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> FT Student <input type="checkbox"/> PT Student	
Address				Telephone #	Sex M _____ F _____
				Driver's License	
Employer Name / Address				Telephone #	
<b>SPOUSE ACCOUNT #</b>					
Last	First	Middle	Maiden	Date of Birth MO _____ DAY _____ YR _____	Social Security #
Employment Status (check one) <input type="checkbox"/> Retired <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> FT Student <input type="checkbox"/> PT Student				Employer / Address	Telephone: #

### 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 River Falls Medical 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

**RIVER FALLS MEDICAL CLINIC  
BILLING POLICY AND AUTHORIZATION**

**Initial**

**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to the River Falls Medical Clinic 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 River Falls Medical Clinic as my primary care clinic with my HMO.

**RECORD RELEASE**

I hereby authorize the release of any information, including medical and billing information, by River Falls Medical Clinic, to my referral doctor and/or insurance company. I further authorize River Falls Medical Clinic to retrieve my external medication history.

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made on my behalf to the River Falls Medical Clinic 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 River Falls, Ellsworth and Spring Valley Clinics about services I have received from River Falls, Ellsworth and Spring Valley Clinics and other care providers unrelated to River Falls, Ellsworth and Spring Valley Clinics. These records may be used by River Falls, Ellsworth and Spring Valley 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 River Falls, Ellsworth and Spring Valley Clinics for purposes described above.

Is River Falls, Ellsworth and Spring Valley Clinics your primary clinic/healthcare home?

Yes     No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Patient name \_\_\_\_\_ MRN # \_\_\_\_\_