RIFE & ASSOCIATES
FAMILY HEALTH CARE

Patient Name: _____ Date of Birth: _____ Age: ____ Email: _____

Address: _____ City/State/Zip: _____

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

Sex: ____ Social Security: _____ Marital Status: S M W D Sep Spouse: _____

Check if ok to leave message at:
__ Home __ Cell __ Work

How do you prefer to be contacted for your appointment reminder? (Check all you'd prefer)
__ Phone __ Text __ Patient Portal

Race: (Please Circle One) American Indian, Alaskan, Asian, African American, Caucasian, Hawaiian-Pacific Islander, Latino

Ethnicity: (Please Circle One) Hispanic or Non-Hispanic **Preferred Language**: _____

Preferred Pharmacy: _____ Location: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Policy Holder: _____ Date of Birth: _____

Address: _____ City/State/Zip _____

Home Phone: _____ Work Phone: _____ Relationship: _____

How did you hear about us? Thank you for your feedback!
__ Website __ Billboard __ Radio __Newspaper __Bus Ad __Google Search __Family/Friend
__Insurance __ Facebook __ Instagram __Yelp __Google Ad __Other: _____

Assignment of Insurance Benefits: I hereby authorize direct insurance carrier payment of surgical/medical benefits to Dr. Rife and Associates Family Health Care, S.C. for services rendered by her/him in person or under her/his supervision. I understand that I am financially responsible for any balance not covered by my insurance
Authorization to Release Information: I hereby authorized Dr. Rife and Associates Family Health Care S.C. to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits.
Medicare/Medicaid: I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request payment of authorized benefits be made on my behalf.
Acknowledgement/acceptance of No Show/24 Hour Cancellation: I hereby agree to the terms that if I am not able to keep my schedule appointment and do not call to cancel my appointment with 24 hours prior to my appointment I will be charged a no show/24 hr. cancellation fee for that missed appointment. **A photo copy of these assignments shall be valid as the original.**

_____ _____
Patient Signature Date

_____
Relationship (if other than patient)

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Medical History Form (Please complete all sections front and back)

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Occupation: _____ Height: _____ Weight: _____ Marital Status: S M D

Your Medical History

Please check below if you have had the following:

__ Aids
__ Alcoholism
__ Arthritis
__ Asthma
__ Bleeding disorder
__ Breast problems
__ Blood transfusion
__ Cancer
__ Chemical dependency
__ Chest pain
__ Depression
__ Diabetes
__ Drug Abuse
__ Eating Disorder
__ Emphysema
__ Epilepsy
__ GI (stomach) problems
__ Colonoscopy
Date: _____
Results: _____
__ Hay Fever/ Allergies
__ Headaches
__ Heart Disease
__ Hepatitis
__ High blood pressure
__ High Cholesterol
__ Kidney Disease
__ Liver Disease
__ Mental Disease
__ Osteoporosis
__ Pneumonia
__ Rheumatic fever
__ Can't fall asleep
__ Early Awakening
__ Drowsy in daytime
__ Stroke
__ Thyroid
__ TB
__ Ulcers
__ Venereal Disease

Other: _____

Medication and Dosages

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergy History

Please list all allergies (i.e. medications, foods, environmental, etc.) and write down your reaction.

_____ _____

Hospitalizations/ Surgeries

Year	Hospital	Surgery or reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Habits

Please check if appropriate

Smoking ___
Packs per day: _____
Desire to quit: _____

Caffeine ___
Daily intake _____

Alcohol ___
If daily consumption:
___ drinks per day
If monthly or less:
___ per week

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Females (13 and over)
Please check below if you have had the following:

__ Abnormal periods
__ Abnormal bleeding
__ Breast lump
__ Nipple discharge
__ Painful intercourse
__ Pregnancy complications
__ Vaginal discharge
Other: _____

Age period started: ____ Last period: _____ Method of birth control: _____ No. of children: _____

_____ _____ _____ _____ _____ _____
Last Pap Results Where Last Mammogram Results Where

Males
Please check below if you have had the following:

__ Erection difficulties
__ Lump in testes
__ Penis discharge
Other: _____

Immunization history

	Month	Year	Never
Last Tetanus Shot:	_____	_____	_____
Last Pneumonia Shot:	_____	_____	_____
Last Flu Shot:	_____	_____	_____

Where did you get your flu shot? _____ Do you get the flu shot each year? _____

Nutrition and Diet
How many times a week do you eat the following?

__ Sweets/candy
__ Fast Foods
__ Soda
__ Dairy Products
__ Fried Foods
__ Meat
__ Fish
__ Bread/ cereal
__ Caffeinated beverages

Occupational History
Please check if appropriate

__ Stress
__ Contact with bodily fluids
__ Heavy lifting
__ Hazardous substances

Number of hours worked per week: ____

Depression screening
Please circle

yes no During the past month have you often felt down, depressed, or hopeless?
yes no During the past month have been bothered by having little interest or pleasure in doing things?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of the staff responsible for any errors or omissions I may have made in completing this form.

Patient Signature: _____ Date: _____

Physician Use only

	Physical Activity	Alcohol	Smoking	Nutrition
Patient advised on:				
Patient given education material on:				

Physician Signature: _____ Date: _____

Patient Name _____

DOB _____

Date _____

Family History

Please fill in all boxes that apply

Members	Year of Birth (if alive)	Alive?	Age at death If deceased	Healthy	Hypertension	Diabetes What Type?	Heart Disease What Type?	Stroke	Mental Illness What Type?	Cancer Type? When diagnosed?	Other	Unknown
Father		Yes No										
Mother		Yes No										
Brother 1		Yes No										
Brother 2		Yes No										
Sister 1		Yes No										
Sister 2		Yes No										
Grandfather Maternal		Yes No										
Grandmother Maternal		Yes No										
Grandfather Paternal		Yes No										
Grandmother Paternal		Yes No										
Son 1		Yes No										
Son 2		Yes No										
Daughter 1		Yes No										
Daughter 2		Yes No										

Total Siblings _____ Brothers _____ Sisters _____ Healthy?_____ **Total Children** _____ Sons _____ Daughters _____ Healthy?_____

If you listed above any family member(s) with cancer, at what age were they diagnosed? _____ If deceased, what age at death? _____

Noncontributory if adopted Yes ____ No _____

Please fill out the reverse side if you have more than two brothers/ sisters/ sons or daughters with significant medical conditions.

Family History

Members	Year of Birth (if alive)	Alive?	Age at death If deceased	Healthy	Hypertension	Diabetes What Type?	Heart Disease What Type?	Stroke	Mental Illness What Type?	Cancer Type? When diagnosed?	Other	Unknown
Brother 3		Yes No										
Brother 4		Yes No										
Brother 5		Yes No										
Brother 6		Yes No										
Sister 3		Yes No										
Sister 4		Yes No										
Sister 5		Yes No										
Sister 6		Yes No										
Son 3		Yes No										
Son 4		Yes No										
Son 5		Yes No										
Son 6		Yes No										
Daughter 3		Yes No										
Daughter 4		Yes No										
Daughter 5		Yes No										
Dauger 6		Yes No										

Service Fees

- A $30 service fee will be assessed for all returned checks.
- A $75 service fee will apply to complete disability form from private agencies
- A 25% fee will be added to your balance if your account is sent to a collection agency and future payments will be on a cash basis.

Your insurance will be billed a "Late or Weekend Hours Visit Charge" if your appointment is 5pm or later on Saturday.

Cases of Divorce or Separation

The parent of legal guardian who brings the patient in for a visit will be responsible for copays and for any balances after insurance is filled.

Work Comp Visits

It is the patient's responsibility to provide ALL the insurance and business information if your visit is due to an injury sustained from a job or place of business. You must have this information released to the front desk prior to your scheduled appointment, and if you fail to provide the office with this information, you will need to pay for your visit or reschedule.

Auto Injuries & Accidents

If your visit is the result of an automobile accident/injury, note that we will only submit claims to your medical insurance that is in you chart. If you do not want this to occur, you must pay for your office visit, then you can submit this claim to the auto insurance policies. We do not submit claims to auto insurance plans. You may pay by check, charge, or debit card on the day of your visit.

Transfer of Medical Records

All transfer request must be on the request form. We will need 7-10 business days to process your request. There is a fee required to coy your chart. That fee is based off of a services fee dictated by Illinois state law, in addition to a charge per page fee. Your copies will be released once the final payment is received. Also, accounts must be paid in full before your copied record will be released.

Illinois Immunization Registry

By signing the agreement below, I agree to have my immunization record included in the Illinois Immunizations Registry. If you do not want your date available in the registry, please ask us and we will provide you with an opt-out of registry form to sign.

Assignment & Release

I hereby authorize that my insurance benefits be paid directly to Dr. Rife & Associates Family Medicine. I will be financially responsible for all non-covered services (copays, deductibles, cosmetic procedures, immunizations, etc.) I also authorize the practice to release any information required to process this claim to the insurance company or third-party payer.

- This release may be revoked at any time if written authorize is received stating the reason for such action
- Patients not in good financial standing with this practice may be dismissed (disengaged)
- HIPAA Rules are compiled within this office

Please acknowledge your acceptance of these terms by signing and dating the form below:

_____ _____

Patient Signature Date

_____

Relationship (if other than patient)

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Notice of Practice Policies

Appointment Confirmation and Special Charges
A call confirming your scheduled appointment will be made prior to your appointment. A message may be left on your answering machine/voicemail if no one answers the phone.

Medications

- Refills- Allow 2-3 business days for refills. Contact your pharmacy 5 days before running out of your medication and ask them to send us an electronic refill request, or you may send us a refill request through your patient portal.
- Physicians covering for PA's do not authorize refills on weekends.

*For your safety, you may be required to make an appointment in order to get a refill.

Controlled Substance prescriptions

- Must be picked up in person, and a photo ID must be presented
- No narcotics or controlled substances will be refilled on Fridays, Saturdays, Sundays or holidays.
- If family member will be picking up a prescription, the office must have that person's name in advance.
- The name of the person picking up prescriptions will be documented in the medical record.

Medications requiring prior authorizations- Note that some medications now require prior authorization from your insurance company, and we no longer issue prescriptions for those medications. Please contact your insurance company for medications that require prior authorization and let your provider know so they can recommend a suitable substitute. The increasing number of insurance plans and variations on formularies they dictate have forced us to set this policy. We apologize for any inconvenience.

Telemedicine

- The laws that protect privacy and confidentiality of personal medical information are also applied to telemedicine and information without your consent won't be disclosed
- A written record of your telemedicine visit will be kept in your medical record, not the actual video
- Although anticipated benefits may be expected from the use of telemedicine, no results can be guaranteed

Referrals
Any type of referral requires 5-7 business days. Referrals are the patient's responsibility and need to be requested prior to having the services rendered. Referrals will not be faxed – they must be picked up by the patient or mailed. Referrals will not be processed if patient is calling on the day of their appointment with specialist/testing. The patient will be expected to reschedule.

Labs
Please allow 7-10 business days to receive lab results. If you DO NOT hear from us within this timeframe please contact the office, so we can investigate further.

Please Note
We do submit claims under our insurance contracts with insurance companies. For all self-pay and non-contracted insurance, payment **must** be paid at time of service. Any balance after insurance payment **must** be paid in **full** within 30 days.
I understand and agree that it is my responsibility to know if my insurance has a deductible, copay, coinsurance, out-of-network benefits, usual and customary limit, prior authorization requirements, or any other type of benefit limitations for the services I receive. I agree to make any payment required during my visit in full. I understand that I am responsible for knowing what facility are covered by my insurance which may include hospitals, labs, and testing facilities. I understand that I am responsible for knowing my benefits with my insurance, which may include coverage for any tests ordered.

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dr. Rife & Associates Family Medicine ("the practice") may use and disclose protected health information (PHI) about myself to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices before signing this consent.

Dr. Rife & Associates Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Robert Rife, Director of Operations, Dr. Rife & Associates Family Medicine, 10755 163rd Place, Orland Park, Illinois, 60467.

With my consent, the practice may mail to my home, or other designated location, any item(s) that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that the practice restricts how it uses/discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, and in accordance with Illinois law, Dr. Rife & Associates Family Medicine staff may call my home or other designated location and leave a message on voicemail, by text, or in-person to myself or any individual I list below to share my personal health information with, in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including test results.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the consent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

Information Sharing: Please list any individuals that we can share your personal information with other than healthcare providers. (ex. Parents, spouse, friends, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Please check box if you **do not** want your personal information shared with anyone.

☐ Please check box if you **do not** want to be contacted by text

_____ _____
Patient/Guardian Signature Date

_____
Patient/ Guardian Name (Please Print)

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Patient Portal Authorization Form

This form must be completed to gain access to the online medical records of a patient, the patient portal. A new patient portal account will be established for those requesting access with the email address provided below.

I agree to the following:

- I must log in to Rife & Associates patient portal with my own user ID and password.
- I will abide by the terms and conditions of the Rife & Associates Patient Portal site.
- Rife & Associated has the right to revoke online access at any time.
- **I am 18 years old or over. If not, the legal guardian will complete all sections of this form.**

I understand that:

- For medical emergencies, dial 911. Rife & Associates patient portal is NOT to be used for urgent needs.
- All communication is sent to the practice, not directly to the provider. The message will be reviewed and responded to or forwarded appropriately.
- I will receive a Rife & Associates patient portal email notifying me when access is available with login credentials.

I understand that Rife & Associates patient portal is intended as a secure online source of confidential medical information. If I share my patient portal information username and password with another person, that person may be able to view my or my child's health information.
I agree that it is my responsibility to select a confidential password, to maintain my password securely, and to change my password if I believe it may have been compromised in any way.
I understand that my activities within Rife & Associates patient portal may be tracked by a computer audit and that entries I make will become part of the patient's medical record.
I understand that access to Rife & Associates patient portal is provided by Rife & Associates as a convenience to its patients and that they have the right to deactivate access to the portal at any time for any reason. I understand that the use of Rife & Associates patient portal is voluntary, and I am not required to use the patient portal.

Secure Email Address: _____

_____ _____
Patient Name (printed) Date of Birth

_____ _____
Signature Date

Complete section below if you are the legal guardian of patient.

_____
Your Printed Name

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Annual Wellness Visit (AWV) FAQ

What is an Annual Wellness Visit?

An Annual Wellness Visit (AWV), unlike your welcome to Medicare visit, is not a traditional head to toe exam. It is an opportunity to set up a prevention plan with your medical provider, review care you are receiving from other doctors, and to receive a cognitive function checkup.

When am I eligible for my first Annual Wellness Visit?

You are eligible for your first wellness visit 12 months after your Welcome to Medicare Visit. Your welcome to Medicare visits must be done within your first year on Medicare.

How often should I get an Annual Wellness Visit?

This is based on insurance, if you have traditional Medicare part B then you would get an AWV every 366 days or after. If you have a supplemental insurance such as (ex: BCBS Medicare, Humana Medicare, UHC Medicare) then you can get your Annual Wellness Visit done at any point, once per year.

Is my Annual Wellness Visit fully covered by Medicare?

If you receive other health care services during your Annual Wellness Visit, for example if your provider treats an existing condition or one that is identified during the visit, **you may have to pay for these services.**
(Ex: requesting medication refills, acute conditions, diabetes follow up, etc.)

For additional information, please head over to **CMS.gov**

I understand that during my Annual Wellness Visit (AWV) and Welcome to Medicare, Medicare may not cover any acute or chronic conditions that are discussed during my visit. I understand I might have a balance left over from my insurance that I will be responsible for payment.

Please let our staff know if you will need a separate visit to discuss your chronic or acute conditions.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Annual Wellness Visit Questionnaire

Please list the Providers that are routinely involved in your care, this includes all specialists:

_____
_____
_____
_____

Do you need help with the following:

Phone:	no	yes
Transportation:	no	yes
Shopping:	no	yes
Preparing meals:	no	yes
Housework:	no	yes
Laundry:	no	yes
Medications:	no	yes
Managing money:	no	yes

Does your home:

Have rugs in the hallway:	no	yes
Lack grab bars in the bathroom:	no	yes
Lack handrails on the stairs:	no	yes
Have poor lighting:	no	yes

Have you noticed any hearing difficulties? no / yes

Do you have a medical power of attorney/ advance directives/ living will?
Please name the person/ people.

_____

Have you fallen in the last year? no / yes

Patient Signature: _____ Date: _____

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Medicare Chronic Care Management (CCM) Consent

Our practice offers a Medicare benefit for patients with two or more chronic conditions, that enables us to provide you with services to oversee your chronic conditions and improve your overall wellness.

As a new patient to our practice, **it is a requirement to enroll** in the CCM program to support in providing you optimal care.

Chronic conditions include but are not limited to:

- diabetes
- high blood pressure
- heart disease
- depression
- arthritis
- osteoporosis

These conditions require extra effort in a partnership between the healthcare team and patient to maintain the best possible overall health and wellness. Our goal is to provide you with the best care possible.

The benefits of CCM include faster response times and personal one-on-one access to our care coordinator, Sharon.

She will provide the following non-face-to-face services:

- coordinate visits with your providers, facilities, labs, radiology, and others
- help with access to your specialists
- coordinate care with hospitals and pharmacies
- assist with monitoring your medications

Also, your provider will develop a personalized and comprehensive care plan.

Medicare requires you to pay your coinsurance amount of no more than $9 per month for each month you receive CCM services. Most patients that have a Medicare supplement insurance plan will have this amount paid for by their plan. All other costs are paid for by Medicare.

Note: **Only one provider can offer this service to you**. Please let your provider or staff know if you have entered into a similar agreement with another practice.

I agree to participate in the Chronic Care Management program.

_____ _____

Name (printed) Date

_____

Signature

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Medicare Remote Patient Monitoring (RPM) Consent

Remote Patient Monitoring (RPM) is a benefit offered by Medicare for an out of pocket monthly fee of $13.33 that provides medical devices that help monitor patient's chronic conditions remotely.

As a new patient to our practice, **it is a requirement to enroll** in the RPM program to support in providing optimal care.

These medical devices help share your health information directly to your physician monitoring conditions such as:

- High blood pressure
- Heart disease
- Diabetes

Program Benefits:

- Encourages wellness
- Decreases chances of Emergency room visits and hospitalizations
- Promotes early intervention by identifying subtle changes
- Provides a sense of security

Program Enrollment

- I understand that it is mandatory to enroll in RPM as a new patient to the practice
- I understand that I will receive remote medical devices to help monitor my chronic conditions
- I understand that this information will be monitored by my physician
- I understand that I will have to pay $13.33 out of pocket for this program benefit
- I understand that results are only monitored during business hours

I agree to participate in the Remote Patient Monitoring program.

_____ _____

Name (printed) Date

_____

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Financial Waiver Form

I understand that in the event that my health insurance, my Medicare insurance carrier, or work comp is not active or current, and/or they deny payment for any current or past visits, I will be responsible for any and all balances due on my account/my family's account.

This shall include, but is not limited to, any and all deductibles, co-pays, and/or services that are not covered under my plan. Payment will be submitted in full to the office immediately.

_____ _____

Patient Signature Date

_____

Relationship (if other than patient)

RIFE & ASSOCIATES
FAMILY HEALTH CARE

Release for Medical Information

TO: _____
Physician's Name

_____
Address

_____
City State Zip Code

_____
Phone Number Fax Number

I hereby authorize and request the release to:

Dr. Susan Rife Family Healthcare
10755 W. 163rd Place
Orland Park, IL 60467

Phone: 708-873-1187 Fax: 708-364-9307

Please release all documents from date _____ to _____ including:

_____ All Medical Care
_____ Radiology Reports
_____ Laboratory Reports
_____ Other

Patient's Name _____ DOB _____

Patient's Signature _____ Date _____

Patient's Address _____

Signature of Witness _____