RIVER CITY
WHOLE HEALTH

FINANCIAL AGREEMENT W/ ATTY. FEES

FINANCIAL AGREEMENT

1. **Assignment of Benefits:** I authorize my health insurance company to make payments directly to River City Whole Health (RCWH) and associated physicians for benefits covered by my insurance contract.
2. **Appeal Rights:** I authorize and appoint RCWH to act on my behalf and / or on the behalf of my covered child (under 18 years of age) or legal dependent as my authorized representative in requesting an appeal of any denial of payment and / or denial of services by an insurance carrier with whom valid coverage exists for medical services. I further direct that any payment made by an insurance carrier as a result of a successful appeal is to be paid directly to RCWH.
3. **Promise of Payment:** I understand and agree that even though I have assigned my benefits to the providers, I remain financially responsible for the payment of medical care and treatment provided to me by RCWH, my attending FNP(s) and / or physicians, or other healthcare providers. Payment is due upon receipt of the invoice. I understand that RCWH is free to declare the entire balance to be immediately due and payable if I fail to make any scheduled payment. I further agree to pay all costs of collection including reasonable attorney's fees, if the account is not paid in a timely manner.
4. **Financial Responsibility:** I understand that I am responsible for knowing the limitation of my insurance, health plan and / or other third- party benefits. I agree to be responsible for paying the full amount of all charges for services that are deemed by the insurance company, health plan or third- party payer to be; (i) not covered benefits; (ii) in excess of my plan's limitations(s); or (iii) not medically necessary, investigational or experimental. I understand that I am agreeing to pay for such services and or procedures in the amount(s) consistent with the RCWH policies and pricing.
5. **Preauthorization Process:** I understand that it is my responsibility to obtain preauthorization prior to a service when preauthorization is required by my insurance company.
6. **Release of Information:** I authorize the release of any medical and / or other information necessary to process my claim(s).
7. **Length of Contract:** I understand and agree that the authorization(s) and appointment(s) above will remain valid until such time as I revoke them in writing to RCWH and my insurance carrier.

_____ _____

Authorized Signature (must be Patient or Legal Guardian Date

_____

Relationship to Patient if Parent or Legal Guardian

____Viewed / Scanned Photo ID

Staff Initials: _____

Date: _____

River City Whole Health
1101 South 3rd West Suite 101
Missoula, Montana 59801
Phone: 406-214-2040
Fax: 888-700-9240

Medical/Social History

Do you currently chew or smoke tobacco? Y N If no, have you in the past? Y N Quit Date: _____
How many packs/cans per day? _____ For how many years? _____
Do you drink alcohol? Y N If yes, which type? (ex. Beer) _____ How many drinks/week_____
Any street drug use (past or present; please specify)? (cocaine, etc.): _____
Do you drink caffeinated beverages? Y N What type (ex. coffee,soda):_____ Cups/day: _____
Are you sexually active? Y N If yes, do you use contraception? _____
How many partners have you had in the last year? _____ Have you ever been knocked unconscious? Y N
Have you ever been exposed to toxic fumes or hazardous wastes? Y N
Have you ever had a blood transfusion? Y Do you use sunscreen: Y N Seatbelts: Y N
Describe your eating habits: (poor, well-balanced, vegetarian, gluten-free etc.) _____
_____Do you eat out more than 2 times per week? Y N
Do you get regular exercise? If so, what kind/how often:_____
Have you ever been hospitalized (please include childbirth (s)? Y N If yes, please explain: _____

_____

_____

Which of the following conditions have you currently or previously been treated for?
Please mark all that apply

□ Heart disease/ Murmur/ Angin	□ Seizures	□ Osteoporosis	□ Swollen ankles
□ High cholesterol	□ Hepatitis	□ Fibromyalgia	□ Shortness of breath
□ High blood pressure	□ Arthritis	□ Insomnia	□ Heartburn
□ Depression	□ Lupus	□ Fatigue	□ Psychiatric Care
□ Gluten Intolerance	□ Hashimotos	□ STD	□ Urination Problems
□ Kidney/Bladder problems	□ Anxiety	□ Mumps	□ Thyroid problems
□ Lung problems/ cough	□ Cancer	□ Stroke	□ Bowel Irregularity
□ Degenerative Disk Disease	□ Migraines	□ Diabetes	□ Headaches
□ Ulcers/colitis	□ Gout	□ Pneumonia	□ Lactose Intolerance

Men Only □ ED Women Only: □ Abnormal Pap □ Menstruation Problems
Last period or menopause date: _____

Please describe any current or past medical conditions not listed above: _____

_____

_____

Please describe any current or past injuries or surgeries (ex: broken arm 2003): _____

_____

_____

Do you see any other specialists? (ex: neurology, cardiology, psychology, psychiatry, etc) If so, please list:
_____
Allergies: _____
_____
Is there anything else you would like us to know about you? _____
_____
_____

RIVER CITY
WHOLE HEALTH

CONSENT TO RECEIVE TEXT MESSAGES FROM RIVER CITY WHOLE HEALTH

River City Whole Health would like to offer you the ability to receive text message reminders for your appointments. In the future, we are also planning to send other health information out by SMS such as result notifications, or that we need to get in touch with you.

The SMS service should not be solely relied upon, as the responsibility of attending and cancelling appointments still rests with you, but we hope this will make things easier.

I understand that message/data rates may apply to messages sent through PRACTICE FUSION to my cell phone and that I may receive several text messages a month. I also agree not to hold RCWH liable for any messaging charges or fees generated by this service. I further agree that in the event my contact/cell phone number changes that I will inform RCWH or be liable for any fees or charges incurred.

I know that I am under no obligation to authorize RCWH to send me text messages as part of this program.

I may opt-out of receiving these communications from RCWH at any time by calling RIVER CITY WHOLE HEALTH @ 406-214-2040 during business hours.

By signing below, I understand the above information and give authorization to RIVER CITY WHOLE HEALTH through its vendor PRACTICE FUSION to contact me by SMS text message to serve me better.

Name:_____

Signature:_____

Date:_____/_____/_____

Cell Phone Number: (_____) _____-_____

River City Whole Health
1101 S. 3rd St. West Ste 101
Missoula, MT 59801
Ph 406.214.2040

RIVER CITY
WHOLE HEALTH

HIPAA Agreement

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Consent and you are adv to do so.

By signing this form, you consent to our use and disclosure to third parties of your PHI for treatment, payment, and h care operations, and for certain marketing purposes, as described in our Notice of Privacy Practices. If you sign this Consent but later change your mind, you have the right to revoke this Consent by delivering to us a written, dated document signed by you. However, such a revocation shall not affect any disclosures we have already made in relianc your prior Consent.

The patient understands that:
The Clinic has a Notice of Privacy Practices. The patients has received, and had the opportunity to review this Notice before signing this consent. This Clinic encourages all patients to review the Notice of Privacy Practices.
The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all notifications available for review by patients.

Protected health information may be disclosed or used for treatment, payment, or health care operations, and for certa marketing purposes.

The Clinic or its business affiliates may use your PHI to contact you with educational and promotional items in the fu via email, U.S. Mail, telephone, fax and/or prerecorded messages. We WILL NOT sell or "SPAM" your personal con information.

The Patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this consent in writing at any time and all future disclosures that require the patient's prior wr consent will then cease. The Clinic may revoke treatment upon the execution of this consent.

The Consent was signed by: _____
Printed Name of Patient or Patient Representative

_____
Signature Date

Relationship to Patient
(If other than patient) _____
Printed Name

_____
Signature Date

Deni Llovet, FNP: Kinsey Fisher, FNP: Sarah Slater, FNP
1101 South 3rd W. Suite 101
Missoula, MT 59801
(406) 214-2040

PATIENT INFORMATION Today's Date: _____

Last Name: _____ First Name: _____

Middle Intial_____Preferred name (if different than first name): _____

Physical Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Mailing Address: _____

Cell Phone: _____ Home Phone: _____

Employer: _____ Occupation: _____ Highest Level of Education: _____

SSN: _____ Birthdate: _____ Age: _____

Sex: M F Marital Status: S M W D Spouse: _____

Gender Identity: _____ Sexual orientation:_____ Decline to answer: _____

Emergency Conact: _____ Phone: _____

Pharmacy: _____ Race: _____

If patient is a minor, parent/guardian name: _____

Insurance Name: _____ Subscriber ID:_____ Subscriber Name: _____

Secondary Insurance: _____ Subscriber ID:_____ Subscriber Name:_____

AUTHORIZATION:

○ All of the above information is true to my knowledge. I authorize treatment of the patient named above.

○ I authorize this office to release to my insurance company, third party, medical facility, or attorney any information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage.

○ I understand that payment of charges is due in full at the time of service unless I have insurance coverage. I understand that failure to pay may result in dismissal from RCWH.

○ I understand that payment may be made in the form of cash, check, or credit card.

○ I understand that there is a $25 charge for returned checks which, with the charge of the previuos visit will be collected by cash or credit prior to being seen at the next appointment and that only cash or credit will be used for any subsequent appointments.

○ I understand that there is a $25 missed appointment fee if I do not call to cancel or reset my appointment 24 hours before I am scheduled.

○ I understand that if I do not pay my bill and my accounts has to be prepared for collections I will be charged an additional $25 fee.

○ I authorize River City Whole Health to leave a message on the phone number(s) I have provided.

○ I am aware of my privacy and confidentiality rights under HIPAA.

○ I have read and understand the above statements and agree to abide by these policies.

Patient/Parent Signature: _____ Date: _____

Family History

	Living	Age (or age at death)	List Serious Illnesses
Mother:	□ Yes □ No		
Father:	□ Yes □ No		
Sisters:	□ Yes □ No		
	□ Yes □ No		
	□ Yes □ No		
Brothers:	□ Yes □ No		
	□ Yes □ No		
	□ Yes □ No		

Has any member of your family (including children, parents, grandparents) had any of the following illnesses?

Illness	Which family member?
Anemia or blood disease	
Cancer	
Diabetes	
Glaucoma	
Heart disease	
High blood pressure	
HIV/AIDS	
Mental Illness/ Depression	
Stroke	
Other serious illness	

Medications & Supplements (Please include dosage and amount taken per day)

Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	
Medication:		Dosage:	

RIVER CITY
WHOLE HEALTH

AUTHORIZATION TO RELEASE INFORMATION – GENERAL

Name: _____ DOB:_____ Phone:_____

Please Obtain Information From:

_____
Name of Provider/Clinic

_____
Street Address

_____
City State Zip Code

_____
Phone/Fax

Please Send Information To:

River City Whole Health
1101 S. 3rd St. West Suite 101
Missoula, MT 59801
Phone: 406-214-2040
Fax: 888-700-9240

I AUTHORIZE the following information to be disclosed:

___ Lab Work	___ HIV Record	___Billing Records
___ Entire Record	___ STD Record	___TB Test
___ Progress Notes	___ Mental Health	___ Imaging Reports
___ Immunization Record	___ Substance Abuse	___ Date(s)

REASON for disclosure of health information:

___ At my request	___ Job	___ Continuing Care	___ School
___Legal	___ Other	___ Insurance	

EXPIRATION of this authorization:

___ 90 days after signature date ___ On this date:_____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected.
- I understand that signing this authorization does not cancel any rights I have under the other state or federal laws.

_____ _____
Client Signature (Parent, or Legal Representative, if applicable) Date

I wish to withdraw this authorization: _____ _____
Date

Witness Signature: _____ _____
Date

☐ Fee Explained ☐ ID Needed ☐ FAX Records
☐ Pick-Up Records ☐ Mail Records

Name:_____
DOB: _____
HRN: _____

RIVER CITY
WHOLE HEALTH

Understanding After Hours and Practice Limitations

River City Whole Health does not provide inpatient care and direct care after hours. You and/or family members are being seen in consultation for outpatient services. By signing this form you understand and agree:

- That you must seek care from a Hospital Emergency Department for urgent or emergency related health conditions occurring during or after office hours. Medicaid patients may seek care after hours at Walk-ins/ Now Cares or emergencies rooms.
- River City Whole Health may not be contacted during afterhours; with the exception of sending messages via our Patient Portal, but responses are not guaranteed.
- Voicemails left on Holidays will be addressed on the next business day.

CANCELLATION POLICY

A cancellation is defined as patient giving notice to our office that they need to cancel less than 24 hours prior to their appointment time. If you have 2 cancellations, you will be taken off the schedule. At that time, you will need to call on the day you wish to be seen and we will accommodate you with an appointment if we have availability. This may be with a different provider than your primary practitioner if that is our only availability. Following 3 office visits scheduled using the previously mentioned method with no cancellations, you will again be able to schedule in advance. No-show appointments count towards this policy.

NO SHOW POLICY

A No-show is defined as not appearing for your scheduled appointment or not calling to cancel prior to your scheduled time. If you have 2 No show appointments, you will be taken off the schedule. At that time, you will need to call on the day you wish to be seen and we will accommodate you with an appointment if we have availability. This may be with a different provider than your primary practitioner if that is our only availability. Following 3 office visits scheduled using the previously mentioned method with no "No-show" appointments, you will again be able to schedule in advance. 3 No-shows will lead to dismissal from the clinic and you will no longer be able to seek treatment or medication.

River City Whole Health has the right to modify this policy at any time for any reason without notice.

Signature:_____ Date:_____

** VACCINATIONS/IMMUNIZATIONS**

River City Whole Heath does not offer or provide vaccinations/immunizations. Patients are referred to the Missoula County Health Department. The Flu vaccine is offered in the fall, while supplies last.
By signing below, you acknowledge this information.

_____
Signature