RIPON FAMILY PHYSICIANS

521 N WILMA AVENUE STE A
RIPON, CA 95366

TELEPHONE 209-599-4211
FAX 209-599-7348

www.RiponFP.com

Conditions of Registration

Patient_____ **Birth Date**_____

Notice of Privacy Practices:

I acknowledge that I have received a copy of the Notice of Privacy Practices (available at our office or on our website, www.RiponFP.com). I understand that I may amend or revoke these authorizations at any time by submitting a signed and dated notice. This authorization will remain valid unless I revise and sign a new form.

I authorize the release of medical information to and from other physicians or medical facilities in order to effectively manage my medical care.

Consent to Communication:

I consent to receive communication, including but not limited to billing information, in any manner, including automated emails, voicemails, written and/or electronic statements, text messages, autodialed calls, and pre-recorded messages. I understand that these communications could result in charges to me.

♦**Authorized Contacts:** I give permission for the office staff to speak with the following individuals regarding my healthcare: □ **NONE, only myself**

_____Phone #_____
_____Phone #_____
_____Phone #_____
_____Phone #_____

Acknowledgement of Financial Responsibility

♦I authorize the release of medical and other information necessary to process medical claims. I authorize payment of insurance claims be made to the physician.

♦I assume responsibility for payment of medical services that are not a covered benefit of my insurance. Covered benefits may be verified by contacting the Customer Service Department of the insurance.

♦I assume responsibility for charges incurred if correct, current, and complete insurance information is not presented at the time of service.

Signature of Patient/Guardian/Representative_____ **Date**_____

If this authorization is NOT signed by the patient, complete the following information:

Printed Name_____ Relationship to Patient_____ Representative's Phone # _____