RYON MEDICAL & ASSOCIATES, LLC.

P.O. Box 497
318 Lacey Avenue
La Junta, Colorado 81050
719-384-0303 (Phone) ~ 719-384-1033 (Fax)

Name: _____ Date of Birth: _____

Social Security Number: _____ Sex: _____

Race: White _____Black _____Hispanic _____Asian _____Other (Specify):_____

Street Address: _____ City/State/Zip: _____

Mailing Address: _____ City/State/Zip: _____

Phone Numbers: Home_____ Cell _____ Work _____

E-mail: _____ Highest education level attained: _____

Place of Employment: _____Phone: _____

Marital Status: _____ Spouse Name: _____

Parent/Guardian: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

In case of emergency, who may we contact? Relationship to Patient? Phone #

1. _____ _____ _____

2. _____ _____ _____

Drug Allergies: _____

Insurance: _____ Subscriber Name/DOB: _____

ID # _____Group #: _____

Pharmacy: _____

This is a list of the people to whom you may disclose my health information. Other than parents/guardians, health information may not be given to anyone that is not on this list.

Name _____ Phone _____

Name _____ Phone _____

If you have a telephone answering machine or voice mail system, our staff may leave messages for you. These messages may contain your confidential information.

_____ Yes, the doctor's office's staff may leave messages on my answering machine/voice mail.

_____ No, do not leave any messages.

If signing for a minor: I hereby give my permission and consent for my minor child; to receive evaluation, care, testing and treatment (Medical and/or Mental Health) from **Ryon Medical & Associates, LLC.**I sign that I am fully aware of the limits of confidentiality. I sign as the full, legal, guardian of this minor child and am responsible for all decisions made on behalf of this child pertaining to his/her physical and emotional health**. Initials of responsible party**: _____

I certify that all above information is correct for self and filled out to the best of my ability.

Signature of Responsible Party: _____Date:_____

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I understand that, under the Health Insurance Portability & Accountability act of 1996, (HIPPA), I have certain rights to privacy regarding my health information.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

Initials of responsible party: _____

FINANCIAL AGREEMENT

- All patients will be expected to pay their co-pay and/or deductible at the time of service, failure to provide payment may result in your appointment being rescheduled.
- We offer the following methods of payment: **Cash Personal Check ($25 fee will be charged on all returned checks) Credit or Debit Card *Visa/Mastercard***
- Payment in full at each appointment is expected if you do not have insurance
- Claims being billed to private health insurance will be submitted after the services are rendered. If the account remains unpaid by the insurance carrier after 60 days the balance becomes the responsibility of the patient.
- Accounts that remains unpaid after 90 days will be turned over to a collection agency. A $40 fee will be charged to your account for collection costs.
- Failure to keep your account current may result in services being terminated with our office, except for emergencies or when prepayment is made for additional services.

Initials of responsible party: _____

I hereby authorize payment be made directly to Ryon Medical & Associates, LLC. I understand I am financially responsible for all charges whether or not paid by insurances, for all services rendered on my behalf or on my dependents. I authorize Ryon Medical & Associates, LLC and/or any provider or supplier of service in this office to release any information to secure the payment of benefits.

Initials of responsible party: _____

Ryon Medical & Associates, LLC., is not currently accepting chronic pain patients. I affirm that I have been made aware of this before scheduling an appointment to be seen by a provider.

Initials of responsible party: _____

I have read and agree to all of the terms on this form. I agree to be responsible for payment of services rendered on my behalf or my dependents. I agree to pay collection costs incurred in attempts to collect on outstanding account balances. I have been given HIPPA Notice of Privacy Practices and understand the chronic pain statement.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

Witness Signature: _____