# Ryon Medical & Associates, LLC

318 Lacey Ave
La Junta, CO 81050
(719)384-0303 Ph ~ (719)384-1033 fax

Patient Name_____ Date of Birth_____

Age_____ ☐ Male ☐ Female Education_____ Race_____

Street Address _____ PO BOX_____ City/State/Zip _____

Social Security Number_____ E-Mail Address_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

**Marital Status:** ☐ Single ☐ Married – Spouse's Name_____ ☐ Widowed ☐ Divorced

**Occupation Status:** ☐ Employed – Employer_____ ☐ Unemployed

☐ Student – School Attending_____ ☐ Retired

Who referred you to this practice? _____

Who is your Primary Care Physician?_____ PCP Phone #_____

Drug Allergies _____

Pharmacy Preference _____ Pharmacy Phone # _____

## IF PATIENT IS A MINOR OR STUDENT (Please check ☐ responsible Party)

☐ **Mother's Name**_____

Date of Birth_____ Social Security Number_____ Phone #_____

Address, if different than above_____

Mother's Employer_____ Phone #_____

☐ **Father's Name**_____

Date of Birth_____ Social Security Number_____ Phone #_____

Address, if different than above_____

Father's Employer_____ Phone #_____

## EMERGENCY CONTACT (Please list someone not listed anywhere else )

Name_____ Relationship_____ Phone #_____

## INSURANCE INFORMATION

**Primary Insurance**_____ ID#_____ Group# _____

Policy Holder Name_____ SSN#_____

Relationship to Patient_____ Date of Birth_____

**Secondary Insurance**_____ ID#_____ Group#_____

Policy Holder Name_____ SSN#_____

Relationship to Patient_____ Date of Birth_____

## AUTHORIZATION

I hereby authorize Ryon Medical & Associates, LLC to leave messages regarding my test results and appointment information on my telephone. ____**Yes**___**No**

I authorize to release medical information to

Name_____ Phone Number _____

Name _____ Phone Number_____

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. I also understand that I must bring all my medications with me to my appointments or the appointment will be rescheduled.

**Initials of responsible party: _____**

If signing for a minor: I hereby give my permission and consent for my minor child; to receive evaluation, care, testing and treatment 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 the decisions made on behalf of the child pertaining to his/her physical and emotional health.

**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.

I hereby verify that all the above information is true and correct as of the date signed below.

Patient Name: _____ Date: _____

Patient or Guardian Signature: _____

Ryon Medical Staff Witness Signature: _____