James D. Pride, M.D.
Eric J. Yegelwel, M.D.
Diane M. Flershem, M.D.
Jason Thalheimer, M.D.
Murray Propes, M.D.
Tyler Kostecki, P.A.

PATIENT COMMUNICATION AGREEMENT

Patient Name: Last ____________ First ____________ Middle Initial ____ Date of Birth ____________

Address ____________ City ____________ State ____ Zip Code ____________

Phone: Home ____________ Cell ____________ Work ____________ Email ____________

Which # do you prefer communication? ☐ Home ☐ Work ☐ Cell

In accordance with HIPAA, please answer the following questions:

May we leave messages on your voicemail or answering machine? ☐ Yes ☐ No

May we leave messages with any other person and/or do you authorize any other person to call regarding your medical information? ☐ Yes ☐ No

If yes, with whom? ____________ Name ____________ Relationship ____________ Phone

If yes, with whom? ____________ Name ____________ Relationship ____________ Phone

May we call you at work? ☐ Yes ☐ No

Emergency Contact: ____________ Name ____________ Relationship ____________ Phone

Preferred Pharmacy: ____________ Name ____________ Town and street of Pharmacy

We are now offering "Guest Pay" for online payments. No more logging in. You are also able to receive E-Statements (email) instead of a paper statement.

I elect to receive my statement via email: ☐ Yes ☐ No

Your email is required for us to set up your login to our Patient Portal.

The patient portal allows you to securely communicate with our staff. You can:

Send messages to and from the practice.
Request refills on your medication.
View lab reports.
Request appointments.
Remit patient balances on our secure portal.

Do you want access to the Patient Portal and utilize its features? ☐ Yes ☐ No

If yes, email address: ____________

PLEASE TURN OVER

Updated 2023

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Please initial each section.

__________ (Initial) I understand there is $25.00 "No Show" fee if I do not provide a minimum of 24 hours' notice of my intent to not appear at a scheduled appointment. If the appointment is for a wellness or physical examination, I understand the fee for "No Show" is $50.00.

__________ (Initial) I understand there is $50.00 "No Show" fee if I do not provide a minimum of 48 hours' notice of my intent to not appear at a scheduled appointment with Dr. Yegelwel. If the appointment is for a consultation with Dr. Yegelwel, I understand the fee for "No Show" is $100.00.

__________ (Initial) I understand there is a $200.00 "No Show" fee if I do not provide a minimum of 5 days' notice of my scheduled procedure with Dr. Yegelwel.

__________ (Initial) I hereby authorize Riverside Medical S.C. to release to my insurance company, third party insurance, or their medical review companies, all medical information necessary to secure payment of medical services. I hereby authorize payment of all medical/surgical insurance benefits to be directly to Riverside Medical S.C. **I understand I will be fully responsible for payment of any and all charges not covered by medical insurance, such as deductibles, copayments, and coinsurances, and for services I have signed a prior agreement to be responsible for if not covered by my insurance.**

__________ (Initial) Payment for services may be made by credit card, approved check, or cash. **Returned checks will be issued with a $35.00 return fee.**

__________ (Initial) Unpaid balances after 30 days will be subject to a $25.00 per month late fee. Accounts 4 months and older may require Collection Agency Action if an agreement between Riverside Medical S.C. and myself (guarantor) has not been formally arranged. All collections fees will be my (patient) responsibility. In the event your account is sent to collections, the collection fee of 35% will be added to your account.

__________ (Initial) Insurance policies determine medical coverage. There are many different plans, independent of each other, within the same insurance company. **It is my (patient) responsibility to understand my medical coverage including but not limited to: (1) deductibles, (2) coinsurance and copayments, (3) services that require a referral. Any services, or referrals recommended by our providers are made strictly for medical purposes.**

WELLNESS COVERAGE – According to the American Medical Associate and your insurance, the term "wellness" only includes:

- Age and gender specific history and examination
- Risk factor reduction interventions such as vaccines, mammograms, prostate screening, and pap smears
- Certain laboratory tests (does not apply to Medicare patients)

__________ (Initial) **A wellness visit/well check is not a complete physical examination and DOES NOT include the Evaluation and Management of chronic conditions or acute illnesses. A separate office visit will be charged for any condition that requires review, continuous treatment, advice and/or diagnosis.**

PRIVACY POLICY

The HIPAA notice has been made available to me by Riverside Medical S.C.

My signature is confirmation that I understand, and initial each section listed above.

____ ______________________
Signature Date

Patients will have 30 days to review and remit payment on outstanding balances. After 30 days, a $25.00 late charge will be applied. Any dispute of balance must be made no later than 30 days from the date of service, or 30 days from the date your insurance makes final adjudication of your claim. After 30 days, unpaid balances will automatically be charged to your credit card account.

______________________________ ____________ ______________________
Card number Expiration date Authorization code (3 digits on back of card if Amex, 4 digits on front)

____ ______________________
Signature Date

Updated 2023