PATIENT REGISTRATION for RIVKA ANN SANDERS, MD
540 Catalina Drive, Ashland OR 97520
Phone (541) 482-0061 Secure Fax (888) 869-7645

______________________________	____/____/____	_Female _Male
Full legal name of PATIENT	Date of Birth	
Marital: _Single _Married _Divorced _Separated _Widow(er) _Partner		____________ Check: _Cell _Landline
______________________________	____________	____________
GUARANTOR (if patient is a minor or incapacitated)	Relationship	Check: _Cell _Landline
______________________________	______________________________	
Street	City	State Zip
______________________________	______________________________	
Email	Referred to or learned of Dr. Sanders by	
______________________________	______________________________	
Preferred PHARMACY / city / street	Previous primary care physician	
______________________________	____________	____________
EMERGENCY contact	Relationship	Check: _Cell _Landline
____________________ ____________	____________	____________
MEDICAL RELEASE authorized for (optional)	Relationship	Check: _Cell _Landline
______________________________	____/____/____	____________
Name of INSURED (if other than patient)	Date of Birth	Sex

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING

For professional services rendered by Rivka Ann Sanders, MD, I fully understand and agree that:

- Medical services are limited to primary care by appointment. I will call 9-1-1 in an emergency.
- I have the right to prior informed consent to, or refusal of, any recommended medical procedure.
- I have the right to prior notice of the fee for any recommended service or medical procedure.
- I have the right to a copy of the Notice of Privacy Practices by request (also at www.RAS.MD).
- My protected health information may be released for medical and billing purposes.
- All rendered medical services incur fees which I, not my insurance, am personally responsible for.
- My insurance may not cover some medical services, such as those via telephone or internet.
- Certain administrative services incur fees, such as copies of medical records, filling out forms, correspondence, teleconferences, services requested by me or on my behalf, failure to show for or cancel an appointment 24 hours in advance, and late payment of fees.
- Optional: By my initials here ______, if my spouse is or should become a patient of Dr. Sanders, I authorize my billing statements to be combined with my spouse's into a single family account.
- Optional: By my initials here ______, ____ is hereby authorized to release the above-named patient's medical records to Dr. Sanders.

______________________________ ____________
Signature of patient or, if applicable, guarantor Date

Internal Use
Rev 2/19 Acct ________ Pt ________